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PSYCHOLOGISTS' DESCRIPTIONS OF SUCCESSFUL AND UNSUCCESSFUL CHRONIC LOW BACK PAIN CLIENTS ON COMPENSATION: A RECONSTITUTIVE HERMENEUTIC ANALYSIS

(C)

by

ROBERT J. FALTIN

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1987

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled PSYCHOLOGISTS' DESCRIPTIONS OF SUCCESSFUL AND UNSUCCESSFUL CHRONIC LOW BACK PAIN CLIENTS ON COMPENSATION: A RECONSTITUTIVE HERMENEUTIC ANALYSIS submitted by ROBERT JOHN FALTIN in partial fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

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Date. July 17, 1987

ABSTRACT

The purpose of this thesis is to describe the chronic low back pain (CLBP) worker's compensation claimant in psychotherapy. The method, which is hermeneutic, involves asking seven compensation board rehabilitation psychologists to describe their successful and non-successful CLBP clients. The thesis offers a summary and interpretation of each case, then partitions the material and identifies 68 themes common to successful clients, 47 different themes common to non-successful clients, and 26 themes which overlap. The thesis then reintegrates the findings into therapist-useable wholes, and offers suggestions for future research.

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CHAPTER 1

INTRODUCTION

A. The Problem

The most common type of chronic back pain complaint seen in the Psychology Department of the Workers Compensation Board of Alberta Rehabilitation Centre involves the nightmare of orthopedic surgeons, namely pain which gets worse with activity, which is dull most of the time, but occasionally excruciating, and which is accompanied by shooting pain and change of sensation down the legs. More often than not, physical confirmation of the complaint is lacking, or in dispute (Chaturvedi, 1986; Hall, 1984; Turk, 1986). Individuals suffering from such disability report not only physical pain and severe mobility limitations, but also family difficulties, loss of friends, personality changes, somatic changes relating to loss of sleep, to stress and constant body awareness, financial strife, and social alienation attendant to loss of employment and the absence of physical proof of disability. Psychological treatment takes place under these complex and sometimes adversarial circumstances.

The principal question examined in this thesis is: What can compensation board psychologists tell us about success and non-success in treating individuals with chronic low back pain? A

non-experimental, descriptive, hermeneutic approach is used to explicate and systematize the answer.

Psychologists within the Workers Compensation Board Rehabilitation Centre Psychology Department (from here on referred to as the WCB Psychology Department) were interviewed and asked to provide detailed specific descriptions of successful and non-successful chronic back pain cases. These descriptions were then interpreted and integrated in a variety of ways.

This area is being addressed because, as Shoemaker, Cox, and Bizaillon (1986 p.1) tell us: "...chronic pain patients, particularly 'low back losers' following a work-related injury have been extremely difficult to rehabilitate" (These authors even suggest that, since the majority of such patients are therapeutically unreachable, research should first center on identifying the small minority who can be helped at all). The problem of what actually occurs with end stage low back pain sufferers exists not only in Canada but worldwide, and not only in compensation, but for our species as a whole (Block, 1982; Harding, 1984; Rollman, 1986).

This thesis will look at the phenomenon in its place in the living world, as perceived by the psychologists who deal with it on a daily basis. It will be argued that there is little point in an approach which would partition the

existing actualities and look at or manipulate mere fragments.

The Setting

The Workers Compensation Board (WCB) of Alberta acts as a self-financing no-fault insurance plan. It administers a pool of capital generated from employers who assume collective responsibility for work accidents which occur on their premises. The management of the Board is government appointed and mandated to work independently of elected political powers of the moment.

Through its expertise the Board is expected to excercise judgment in compensating and treating the injured worker and to provide assistance to those living with a permanent handicap as well as those returning to employment.

The Board's major component branches are: administration, financial assessment of employers, claims divisions dealing with worker entitlement, and treatment services, including psychological services, vocational rehabilitation, physiotherapy, occupational therapy, medicine, and the like. Approximately 60,000 employers report to the Alberta WCB, and some 30,000 cheques to injured workers are sent out every month. From the many thousands of active cases, about 3000 each year are referred to the Rehabilitation Centre, and of these, 1300 or so are referred to Psychology,

mostly for non-treatment services such as vocational assessments. About 600 psychology referrals each year are for psychotherapy.

Among compensation systems in the Western developed countries, the Canadian system is among the best in terms of financial generosity, service delivery and cost effectiveness. It is demonstrably superior to both the United States and the current British model (Harding, 1984). Of the various Canadian compensation systems, Alberta's is without question above average in the size of awards (Harte, 1987) and speed of claim response and appeal processing time (Ogsden, 1986).

The Alberta compensation system was developed in response to demands of labour unions at the turn of the century, and its chairmen were alternately union and business people. A no-fault compensation plan such as the one in effect in Alberta since 1915 is cheaper than privately administered insurance plans, and quicker and more effective in delivering payments, and more economical than litigation-based systems (Gersuny, 1981 p.24-5,). The Alberta approach to compensation is of course far from an ideal answer to all problems posed by human vulnerability, aging, exposure to long acting stressors and substances, and the rest of the dilemmas confronted by embodied beings in the process of controlling the material world of the workplace. The system is also currently at the heart of intense political

debate. The issues of this thesis, fortunately, do not rest on specific characteristics of this compensation system but deal with what occurs in a helping encounter between a social organ and an injured individual where somatic, temporal, interactional, or psychological complexities interfere with expected improvement. Because of the universality of the problem of chronic low back pain the issues examined have broad significance.

Conflicting Visions Within the Compensation System

Despite the apparent advantages of a no-fault system, the various forces involved continue to pull at the seams. A recurring problem for the psychologist is the basic incompatibility between human experience and legal precedent. An organization as large as the Alberta Board, and one involved in such a contentious task as paying one party's money to another for subjectively reported pain and disability requires rules to function, and it is these rules which at times make the psychologist's job difficult.

A myriad of technical details will determine if the worker has an easy or difficult time with the compensation system. This relationship in turn relates back to recovery from the injury, and this in turn effects the social and vocational prospects of the injured worker. The psychologist is by no means excused from the play of competing forces. Records and notes are available to all parties, and psychologists are often called to give

information and recommendations at appeal hearings. At times employers, trying to retain affordable premiums, attempt to convince the Board that a worker's injury pre-existed employment, and they can and do take the Board to court to contest awards which they consider too generous. Claimants sue to contest awards they consider not generous enough, and involve unions, politicians, the press, and the provincial ombudsman in financial or treatment disputes. The no-fault nature of compensation in Alberta is such, however, that the claimants cannot sue the employer directly, though that employer is often the one party whom they consider responsible for the accident and against whom their emotions rail most intensely. (The responsibility for controlling worksite safety conditions rests with the Department of Occupational Health and Safety, and employer safety performance is, additionally, reflected in size of the employer's WCB premiums).

Still, despite these complexities and conflicts, Gersuny, (1981), Wente (1984) and others amply document the much greater difficulties involved in litigation-based compensation.

It would be a convenient world in which painful injuries were always due to discrete, major, and preventable mishaps. Commonly, though, in chronic low back pain the precipitating mishap is minor and neither remediable nor preventable (Cailliet, 1985). Often the worker tries to stay

on the job and work through the initial pain (Ross, 1987). Delay in reporting can make acceptance by the Board more problematic, despite the fact that most back injuries resolve themselves in short order and that the typical front-line worker is known to be unwilling to take time off for passing problems.

If the back pain does not resolve, and the worker reports it two weeks later, confusion about time and place, and co-workers who witnessed the triggering event can conspire to cause difficulty with acceptance. Still, because of the large sums involved, rules of prodecure must be followed. Similar complexities of rule and procedure accompany other aspects of the process, from specificity and appropriateness of medical advice, to re-employment assistance, transportation and home care allowances, to calculation of pre-accident income, to settling the percentage of pre-accident wage to be covered by compensation (Open letter to the Manitoba Employees Compensation Board, 1985).

People in the workplace tend to trust the compensation system, but perceived mistreatment at the start of contact with an individual accident victim can warp the relationship. Under such conditions, for some, the WCB becomes suspect, for others the whole social tapestry begins to unravel when their problem goes undocumented, unresolved and uncompensated.

Non-injured co-workers do not want to listen to conspiracy theories about the safety net called the WCB because such theories make everyday functioning on the job impossible. The injured person who is on poor terms with the WCB (as many Psychology Department clients are, due to the lengthy and poorly understood nature of chronic low back pain), may thus be full of rage, with no ready audience or target.

In many cases, the conflict between the written rule and the subjective world of the low back pain sufferer exists from the initial acceptance of the claim. There is an expectation of improvement along general actuarial time lines by both the worker and the compensation system. There are traditional sequences of medical treatments to be carried out, from conservative to radical. There are schedules for appointments for treatment programs and surgery, sometimes with long waiting periods. If improvement does not take place, attributions are inevitably made, by both sides.

To make things even more complex, today's intellectual climate seems to view waged labour as something like Bosch's painting "The Hay Wagon", an overloaded thrash heap full of vicious fools, each cutting throats to reach the top of a meaningless frenzied pyramid. This view paints the Compensation Board as pushing those who have fallen off this wagon back onto it. While it obviously has some merit, such a view does not quite account for the dread

felt by the working person torn out of the fabric and left to disintegrate in self-doubt, in TV-watching, in drugs, obesity, and closely monitored purposelessness.

As May (1967) proposes, man is only meaningful in relation to his world, and when that world is work, earning a wage, supporting a family, making a material difference, a tearing away will be painful. The low back pain client cannot live without social support, and is not able to earn it any way other than by doing what does not seem possible, that is, getting better and going back to work. However, it is not necessarily the worker denied compensation who is of most concern to the psychologist. As we shall see, the rending is traumatic even for those who have full and permanent financial support.

The Low Back Pain Client seen by the Compensation Board Psychologists

A return to work takes place in the vast majority of Board cases. It is non-return which brings the clients to the Rehabilitation Centre and sometimes to the attention of the Psychology Department. These low back pain clients have almost universally been through all available physical treatments, usually more than once. The psychologists interviewed for this research thus deal with individuals who are not only at the limit of the compensation process but at the very fringe of presently available

therapeutic accessibility anywhere, at any cost.

Clients who reach the Psychology Department are mainly people working in the physical domain, generally labourers or those providing strenuous physical service to others, such as nurses and nursing aides. The clients of the Department typically work as employees of others, and have few intellectual pretensions, or skills for dealing with empty, unstructured time.

Whatever the combination of specific factors, few workers in this situation have patience with the system's necessary insistence on dividing the problem into pre-existing, aging, and work-related components, the waiting for appointments, or for lengthy explanations and minor bureaucratic mixups. The clients typically expect therapists and doctors to do their job, and since they are not getting better, the clients are often tempted to suspect that this is due to intentional acts of an adversarial opponent.

These compensation claimants do not easily accept the irreversibility of some somatic problems, or the possibility that psychological factors may be involved in the persistance of the complaint (Bakan, 1968). A common attitude among compensation clients is: "I will not leave here until I am completely cured, and until I know that it will never happen to me again." Compensation psychologists tell us that when that result is accepted as unattainable, the client often attempts an attribution that can lead either

outward, into paranoia, or inward, into self dissembly, depression and immobility.

There is little doubt that chronic low back pain constitutes one of the invisible plagues of these times (Hall, 1984; Turk, 1986). The notion of lifelong irremediable suffering is hard to accept in this era of technological wonder. Nevertheless, half a million people in Canada are partly or completely disabled by backpain, and some 10 million workdays are lost annually to it (Block, 1982). In a study conducted by Block (1982 p.51) he found that: "No pathological basis can be found to support pain complaints in as many as 78 % of those who are severely disabled by low back pain. Thus traditional medical treatment which is aimed at removing a pathological process, may be inappropriate for a large number of these individuals."

The difficulty of treating low back pain sufferers is also reflected in the admission data from pain clinics. In these clinics the mean duration of the problem before admission is 8.7 years. The mean number of failed surgeries preceding admission stands at 2.5, and the mean number of previous hospitalizations is six (Block, 1982). Significantly, these private clinic clients have no financial stake in remaining disabled.

In compensation as well as in private clinics, when standard treatments fail the clients are generally sent to psychological services; then they,

together with the psychologist, fall into the chasm between what should be (improvement within so many weeks), and what is, namely continuing pain and disability.

Psychologists' Position and the Social Framework

The functions of the Psychology Department include: vocational assessment, assistance with lower level somatic problems through biofeedback, stress management, relaxation training and pain control training, and individual counseling to help the client cope with trauma, with phobias, with terrifying dreams, and other typical counseling issues. Such counseling can also involve the family or significant others to help reduce pressures at home.

Intervention with the compensation system takes place when the psychologist tries to explain the client's position or behaviour to ease client-system conflicts, and when assessment of the degree of psychological damage is necessary to help set the rate of compensation. Considering the often adversarial nature of the system, each of these functions has its ethical and practical perils.

Ideally, the psychologist is working both for the Board and for the client, with a goal of returning the client to full function and employability. The

reason why the client is being seen in the Psychology Department rests on the assumption that there are significant or unusual psychological factors which interfere with such return to full function, and that these can be effectively addressed. While this judgment was in the past usually made by a functionary of the compensation system or the external physician, the Department now provides lectures and brochures to all incoming clients, and a growing portion of the Departmental clientelle now consists of self-referrals.

One problem for the working compensation psychologist is that there is little information about what actually happens to people under the extremes of social, economic, and physical stress encountered over long periods of time in settings such as this. The education of psychologists, and the available research fall short of providing sufficient entry into this complex situation.

Clinicians recognize that complete elimination of pain is not possible for many people with chronic pain (Barber & Adrian, 1982; Brena, 1978). Still, most do believe that therapy can result in improvements in mood, level of physical activity, vocational productivity and social adjustment as well as in reduced use of medications for pain and reduction of unnecessary visits to physicians (Dolce & Raczynski, 1985). They also expect to be able to assist clients in restructuring their understanding of the situation and in becoming more effective in tolerating and controlling it. But despite present efforts to

include psychologists in earlier phases of treatment, the function of the WCB psychologists still consists largely of dealing with people at the end of the line for whom all available treatments failed to provide sufficient solution, and under whose feet the societal safety net has developed rends. The psychologists are, therefore, residents of a poorly mapped territory in urgent need of exploration.

It is the aim of this thesis to use the WCB psychologists to describe that territory and to generate a coherent understanding of what happens there.

Lack of Relevant Research

A common complaint in the Psychology Department is the distance between psychological research and practice. K.G. Ferguson (1983) supported this view by proposing that nothing relevant had been added to the area of applied clinical psychology in the last 40 years. The very presence of tens of thousands of chronic low back pain sufferers incontrovertably shows that effective treatments do not exist in many cases. Another argument for the need for a thesis such as this comes from the meta-study conducted by Berman and Horton (1985) which demonstrates that efficacy of trained therapists is not notably superior to that of paraprofessionals. For all these reasons, the capture of real life for psychological study seems a very necessary endeavour.

However, such research can hardly be based on the standard empirical means. Laboratory pain studies are of limited help to the clinician. They takes place in a time-limited frame, where someone, either the researcher, the subject, or a clock is in control of the adversity. Dread and attribution are therefore absent. Pain in the real world is an entirely different event, under no one's control, full of dread and poorly understood causality, and that is why the client is sitting there, facing the psychologist. While research information on dealing with the somatic aspect of pain can be useful, it is the psychological aspect of victimization by an unspeaking and unfair fate which is our first therapeutic hurdle.

Psychology's position in this dance is not particularly enviable because, as Bakan (1968 p.75) points out, the patient's ego has an aversion to accepting complicity in pain, in accepting that the pain may be even partly psychological or self-referrential. This makes it difficult to cast the client, sitting there grudgingly in one's office, into the usual stream of therapeutic jargon. This relationship between ego, soma, pain, exhaustion, loss of faith, blame, acceptance of help and readiness for change is extremely complex in the compensation setting, and not reducible to individual or simple factors.

Disappointingly, psychological literature bulges with research which discounts the patient's claim of pain and limitation, and too readily accepts

the medical pronouncement of its absence. Fordyce, Shelton & Dunmore (1982), for example, believe in resolving limitations caused by chronic pain with gradually increased demand. In their model the therapists decide what a good goal for the client should be and after determining the baseline, divide the needed improvement by the number of sessions available to achieve it. If the clients fail to do the required amount at speed, they have to do twice as much, slowly. Such an approach is reasonable only as long as one assumes medicine is a complete and accurate science and can meaningfully pronounce on the extent of pain and disability. What this approach assumes about human relationships is even more frightening. The example does illustrate, however, that the client's presentation will eventually reflect not only subjective factors but also the belief system of previous treating professionals and settings. Psychologists at the Rehabilitation Centre do report that some clients are hard to talk to because they are soured by the excess of enthusiasm they encountered in previous psychotherapy. By the way, clients of the Psychology Department fill out from two to as many as five post-treatment evaluation forms. A forceful approach such as the one advocated by Fordyce et. al.(1982) would certainly be objected to by the clients, and shortly discontinued.

The advantage of the current research effort is that it is based on data

gathering from multiple reporters, utilizing a variety of treatment techniques, with actual clients in normal treatment circumstances. The seven psychologists portray their successful and unsuccessful cases and use their years of experience and acquired perspective to select specific cases and focus on issues to be emphasized. In as much as is possible under the circumstances, we thus acquire a multifaceted portrayal of a breathing, living reality.

The Role of this Thesis

This thesis will draw on the therapeutic experiences of the psychologists engaged in this complex situation of treating chronic low back pain clients in the workers' compensation setting.

The method involves a gathering of diverse viewpoints of the seven compensation psychologists by asking for their descriptions of successful and non-successful cases. From this is derived a systematic description of what occurs in this setting. This thesis is necessary because the situation is at present so poorly understood.

This thesis is not an instrument to measure or improve the specific efficacy of the Psychology Department, nor is it a means of comparison between one such department and other treatment settings. To my knowledge, there are no comparable settings, because the responsibilities of psychology

departments in those compensation boards in Canada which have them are radically different.

To use this thesis as a means of service evaluation would risk sending the whole service careening toward satisfaction of some specific criterion which appears valid at this place and time.

"Success" and "Non-success" are not explicitly defined for the psychologists interviewed. The dichotomy is allowed to arise from the multifaceted aspect of their choices themselves. As far as I can determine, no acceptable criteria of success and non-success exist, and those readers looking for explicit definition of such criteria in this thesis will be disappointed. At this point in the inquiry we simply need to develop a broader sense of the situation itself. But despite the hazy nature of the dichotomy between success and non-success, the reader will find that the distinction, though not explicit, is clear, convincing, and informative of the situation in which it is made.

The distinction between success and non-success, left as it is up to the understanding of the interviewees, is also used as a lever to bring the whole of their therapeutic experience out into the open. The results are at times surprising, and they are in all cases educational.

The steps involved in a reconstitutive hermeneutic analysis which

followed the interview process did not take place in a vacuum. As we shall see in chapters five and six, the interviewing and re-interviewing process had an effect both on how the psychologists thought of their cases, and on the way I perceived the meaning, the limitations, and the potential of this research task.

Limitations of this Endeavour

This thesis is not a hypothesis-testing instrument. Its limitations are the limitations of the reporters, the observer, the situation, and of the author as both actor in the setting, (a working psychologist at the Compensation Board) and interpretor of the data. Nor is this thesis a political statement about compensation, the nature of employment, or of social organization. That discussion is, I believe, best left to the greater wisdom of the public process.

The most pronounced limitation of the thesis is that it gathers its materials second hand, not from those experiencing success and non-success (the clients), but from intermediaries (the psychologists). For a number of reasons*, this is unavoidable. But while the extra layer of interpretation may cost us some immediacy, it can and does add perspective, distance, and scope; principally because the viewpoints of the psychologists differ, and because they are all involved in the step-wise process of developing the final

understanding of what happens.

A further limitation involves the need to present not the original terviews, but only summaries and interpretations. As we shall see in Chapter 4, there is simply no way to sufficiently disguise the raw material well enough to prevent identification and guarantee the confidentiality which was promised to the sources.

Chapter Summary

This thesis examines the question of what can compensation board psychologists tell us about success and non-success in treating individuals with chronic low back pain. This unique treatment situation has so far been poorly served by psychology in terms of actual research, therapist training, and development of suitable research methodology. This thesis takes a phenomenological/hermeneutic approach in an attempt to develop an understanding of the complex problem and to express it in comprehensible and useful terms without denying the multifacetted nature of the existing situation.

* The reasons why first-hand information from or about the clients themselves is inaccessible, particularly by nomothetic means, include the fact that there is no way to construct treatment groups which would in any meaningful way be simultaneously homogeneous along the dimensions of

physical status (which is with these clients in constant flux and dispute), personality, and the social dimension, as well as attitude toward the WCB and toward psychological treatment (these being the most commonly mentioned variables contributing to treatment success. There are, as we shall see, many more). Without such simultaneous homogeneity, comparisons of groups of manageable size are not likely to be meaningful. In addition, clients are not likely to consent to be either in an "experimental" treatment group, or in the "non-treatment" group, and neither is the compensation system likely to tolerate the notion of treatment denial for the controls. Further, clients or their representatives would likely insist on right of review of the procedures and the results. The compensation system would certainly insist on such a right, though perhaps in indirect form. In addition, neither the compensation system nor employers nor the clients would be much inclined to carry the financial burden for either the research itself, or for the 'overhead' such as therapist time, space and clerical and computing services, without a say in determining the dimensions to be assessed, and those to be left alone. For these reasons and for reasons mentioned elsewhere in this thesis, the present research uses secondary sources, the treating psychologists. It relies neither on financial support from the parties involved, nor on permission of access, except from the interviewees themselves.

CHAPTER 2

LITERATURE REVIEW

A. CHRONIC LOW BACK PAIN

By way of introduction let us look at some highly condensed examples of medical and non-medical hypotheses about the nature and cause of chronicity:

a} the clients are suffering not from pain, but from habitual pain-behaviours,

b} chronic low back pain reporters are all after money,

c} it is the fault of the social system in which we are all exploited, and no joy and no relaxation are allowed,

d} the clients are stubborn and need to prove that they are right and that there is something structurally wrong,

e} it is all caused by secondary gains, by the reinforcing effect of attention and lassitude,

f} it is the absorption of salt into interstitial liquids that goes with depression which causes expansion of the discs and subsequent malfunction of surrounding tissues,

g} the primary cause is microscopic physical wear and tear on the soft tissues and facet joints,

h} the complaint is due to inadequate personality, the clients are

chronically unable to handle life on their own,

i} it is the compensation system's fault, it creates its own dependents to perpetuate its existence,

j} the neurotic individual is more tense than the average person, as expressed in muscle contraction in the paravertebral muscles, or in the contraction of chest and stomach muscles which the paravertebral muscles then have to counterbalance. These contractions cause compression on the discs and this leads to protrusion of the liquid nuclear disc matter, or compression and drying of the disc, or any one of a myriad of other chronic problems, including nerve impingement,

k} the client reports pain as a substitute for a plea for intimacy,

l} overeager toilet training by parents has caused the clients' gluteal muscles to be permanently overactive,

m} pain is the result of lack of proper patterns of nerve stimulation,

n) the clients suffer from sensory deprivation or other consequences of prescribed bedrest and inactivity, and would have been better off to stay on the job,

o) the clients suffer from the "pain-spasm" cycle,

p) they suffer because the painful experiences which accompany prolonged low back disability conspire to make the client less mobile, and

this in turn leads to shrinkage of muscles, ligaments and tendons, furthering the disability,

q) the clients suffer from undiagnosed sacroiliac joint hypermobility.

For the low back pain client there is the uncertainty in physical diagnosis, unrelieved pressure of social expectation, loss of sleep, confusion of the drugged state, interpersonal stress, the barrage of health provider encouragements, the need to attest to one's internal state before powerful and sceptical others; and no one to turn to in day after day, month after month grip of suffering. While counseling services are, as we shall see pivotal in recovery, we do not really know why. Is it because they bring the client to accept psychological culpability in the complaint? Because they provide a supportive sounding board? Because they offer direction and cognitive guidance in times of utmost dread and turmoil?

Shontz (in Neff,1971) describes five stages of adjustment to disability: Shock, expectancy of recovery, mourning, defense, and final adjustment. Among the compensation claimant's life events the belief in the efficacy of treatment, social status, luck in finding re-employment, spousal relations and so on, all play a role in the passage through these 'stages'.

Internal and external processes intertwine to form a complex and fluid situation for the chronic low back client, and, as we shall see, the

psychologist attempting to intervene needs to be aware of the numerous influences which are in constant flux.

Complexities Imposed by Self-Reference

An old "Ziggy" cartoon showed a patient in the doctor's office; the physician was explaining: "Don't worry about it, everyone feels lousy these days."

A "centralist attribution" would search for personality factors which would explain Ziggy's inability to deal with the cards that have been dealt him, or they may look at his need to manufacture problems so that he can take on the role of sufferer and satisfy his need for the physician's attention.

Shonts (1971, p.33), countering such personality attribution, proposes that: "There is no correlation between physical disability and personality maladjustment." Similarly, Florence, (1980) states that despite the presence or absence of physical features to explain the pain, all pain patients (the 'organics' as well as the 'functionals') behave the same, and so do other people at the end of their rope.

Making a behavioural centralist interpretation of the chronic pain problem, Fordyce (1976) states that the sufferer is the victim of faulty learning forces, and proceeds to alter the reinforcers involved. For example, Fordyce (1976 p. 206) proposes teaching the patients' spouse to reinforce

'well behaviour' and ignore pain expression.

However, returning to the compensation setting we can see that teaching the spouse to ignore complaints which the injured worker may no longer be able to express to anyone else, and to encourage that spouse to ignore pleas for assistance may not quite be perceived as helpful, but quite possibly be seen by the suffering individual as a final indecent betrayal by the world.

Bateson (1979) argued that betrayal and abandonment are often weightier issues to a person than is material advantage. He proposed that the rain dance was not so much meant to bring rain as to affirm that the tribe's place is still within the domain of friendly forces. Some low back pain sufferers engage in a similar ritual, the search for a medical certificate documenting pathology which would not only help get rid of the complaint, but also legitimize the sufferer's claim to be a truthful, honourable person.

The nature of pain: Buytendijk (1961 p. 2) tells us that: "Pain is painful in the double sense, since it is also a puzzle tormenting us." This is particularly true in low back pain cases where structural explanations are not known. This puzzlement is likely to be even more intense today than it was in Buytendijk's time because of the present conviction that everything is doable, and that there is nothing inevitable about either suffering or death (Lasch, 1979).

Since there has also been real progress in medical technology, the long-suffering clients are indeed puzzled about why they have been left out, why they in particular are disbelieved, abused, and abandoned without cure. To quote Buytendijk (1961 p. 58): "This sense of abandonment of the human being to pain has its direct result in a cleavage of the self and the body." The body thus becomes the enemy. As pointed out by Neff, (1971 p.37) our early body-image has a shameful component. When body control fails, that shame returns.

Lack of physical strength is, in the working world, a loss of tenure and respectability. Loss of control over eliminative functions, which is occasionally an aspect of chronic low back pain, is usually devastating.

The question of pain attribution has existed for millenia. To summarize Melzack (1973): under normal circumstances, an active individual without ulterior motives can tell what occurs peripherally and can attribute acute pain accurately to location and cause. However, physiological changes, emotional state, cultural embeddedness, and particularly the passage of time while in pain can alter that reliability of the processes involved.

The centralist argument which places responsibility for the problem onto psychological or central rather than peripheral processes leads to an immediate complication when applied in the compensation situation, namely

the psychologizing of pain. In the most simple form, it leads to the client claiming that the pain is real and a responsibility of the Compensation Board, while the compensation functionary pronounces that the pain is psychological, that is, unreal, non-compensable, and the clients' own responsibility. (This dichotomy of attribution has recently been altered by legislative recognition of the legitimacy of psychological disability).

In any case, the issue of client reaction to this psychologizing of pain becomes a problem in itself and makes the psychologists eventual job harder.

An example of central (personality) attribution of pain proneness is offered by McCnab (1977 p.112) who describes his vision of the three basic personality types found among chronic pain sufferers:

1) The Racehorse, a fighter who hyperextends under threat aggrevating the back pain problem. Will do well with conservative treatment.

2) Razor's Edge: the hysterical attention-seeking contortioninst. Medical attention won't help him.

3) The Worried Sick: he retreats into hypochondriasis under the pressures of life.

Such re-direction of attribution to the sufferer's own personality has a seemingly irresistable attraction when physical intervention has failed and the patient's complaints remain or grow more intense. Kobasa, Maddi, and

Pucetti, (1982) argue that hardy people are curious and find their own experience interesting, and that they believe themselves to be influential in future change. People who are not hardy, on the other hand, see themselves as powerless in the face of overwhelming force and find their life meaningless, boring and threatening. They have no belief in positive development and like things best when there is no change. When stress occurs, these not hardy see no reason to expect a positive outcome, so when injured they become dependent, and that dependency prevents improvement.

Central models thus tend to place responsibility for disability on the clients, and make them the perpetrators as well as the victims.

The Nature of Suffering: Proust (1951) illustrated the difficulties involved in attribution of the cause of suffering; a discussion which is of some antiquity. Young Marcel, as the reader may recall, had an extraordinary fondness for his mother. On one occasion his stern and punishing father, responding to the boy's unhappiness, sent his mother to spend the night with Marcel, making the boy unexpressibly happy, but also pegging his misery and display of suffering as an involuntary disorder, a visited evil rather than a voluntary fault, one for which he would otherwise have been punished. "I could weep henceforth without sin," thought Marcel, and this terrified him because he saw in it a strong temptation, or worse yet, something that would

suddenly overcome him, unbidden, in moments of unhappiness and need.

In everyday situations the degree of suffering is related substantially to our position in the external world. Thibault and Kelley (1959) argue that we employ a comparison level for evaluation of outside events. Things which happen to us above a personal standard of expectation make us happy, those below, unhappy. These authors propose that the comparison level fails to change with injury and the concept of what is fair remains where it was, so that most new events after disability make the individual unhappy because they are inferior to former accomplishments and earnings.

Beck (1976 p.84) similarly proposes that depression is devaluation of domain, while mania is the perceived gain in domain. Johnson (1971), looking at somatically oriented hypotheses dealing with pain and suffering also found the most productive to be parallel of the above, on the bodily level, namely that chronic pain relates to the incongruity between the physical sensation and expectation, and found that sufferers who expect worse typically reported less pain. Those who thought they deserved better, or that better could be had, complained and suffered more.

There is, of course, far more involved in suffering than getting one's way, through a (perhaps involuntary) change in emotional stance. With low back injury the very order of life experience is altered.

As the individual had matured and acquired more experience in life, a growing number of processes could be treated as background, without focal attention. The grammar, the rules and procedures of life and work, became automatized. With injury, a radical change in self-definition forced the client to attend to many more things, to once again deal focally with lower level processes such as movement. Higher level processes like social role and self-worth become undermined by such return to primitive concerns.

As Frank (1977 p.316) notes, people become demoralized when they cannot meet the demands of a situation and cannot exit. Depletion and exhaustion further change self-definition and force more re-assessment, once again downward. All this takes place in a situation where, typically, the client lacks credibility because of either showing no physical signs of damage, or because the procedures for correction of structural deficits are complete and no improvement has occurred.

Issues Facing The Psychologist

Back Pain and Psychological Factors: A recent survey of the roles of psychologists in Canadian pain centres (Von Bayer and Genest, 1986) tells us that non-therapy client contact typically includes: interview and activity records, physiological and biofeedback measurements, social history taking to see if the pain is associated with past events, psychometric personality

assessments, vocational assessments, and interviews with the family. Most common forms of treatment reported by the clinicians in Canadian pain centres are: cognitive therapy, biofeedback, hypnosis and short term psychotherapy. Attention is also usually given to weight problems, addiction, social withdrawal, under-assertiveness and control of anxiety and anger. Means of treatment vary from lengthy in-patient stay to home visits by field workers. Little time is typically spent on research. Clinicians in these locales recognize that elimination of pain is not always a realistic goal. They do believe that therapy can result in improvements in mood, level of physical activity, vocational productivity and social adjustment as well as reduction in use of medications for pain, and unnecessary visits to physicians. The services offered by the Psychology Department also follow this pattern.

The compensation psychologist is usually faced with deciding whether there are psychological issues causally involved in the client's low back complaint. The following literature speaks to arguments for and against such attribution.

Is it true that happy people don't get sick, (Sheehan, 1978), and that unhappy people (specifically the depressed) respond poorly to medical treatment (Romano 1985)? Perhaps, as William Osler commented (in Murphy, 1981 p.102): "There are people in life, and there are many of them, whom you

will have to help as long as they live. They will never be able to stand alone." Or, as Sartre argues, (Sartre, 1969) the patient can be acting in "bad faith", misrepresenting the source of nausea, despair, and dread as disease.

Further on this relationship of happiness and health, Anna Freud (Szasz, 1957 p. 244) observed that orphaned children are more hypochondriacal, and Schmidt (1985) noted that chronic low back pain patients (who typically have a negative self concept) demonstrate poorer physical performace which is unrelated to pain level, that they believe too much in rest and subjectively misevaluate exhaustion. The unloved must, perhaps, love themselves more, or at least protect themselves better than the rest of us.

Granted that the clients are experiencing 'unhappiness' in one form or another, it may be that the various types of negative self-states are not separate entities. Watson and Clark (1984) argue that anxiety, neuroticism, and other typical related traits are all attributes of one stable factor. High negative affect individuals typically experience this state across situations, at all times, and even in the absence of stress and pain. They are more introspective and tend to dwell on themselves, and may be identifiable as complaint-prone even by non-professionals. Perhaps it is true for such individuals as it was for Montaigne that:" My life has been full of terrible misfortunes, most of which never happened" (Carnegie 1953 p.10).

In terms of this centralist argument we can assume that this perpetual life of anxiety and somatic tension leaves a trace and exacts a bodily cost in the form of chronic pain.

Accepting the proposition that psychological factors have a pivotal role, Engel (1959) divides chronic pain sufferers and the suffering-prone into four main groups:

1) conversion hysterics, characterized by a theatrical indifference or overconcern with the symptom,

2) the depressives, who see pain as atonement or a means of escape through analgesia

3) the hypochondriacs, who cannot stop perpetually describing, being obsessed with pain, and

4) the schizophrenics, beset by unrelenting delusions labelled pain, by bizzare speculations re. bodily functions characterized by macabre analogies, and difficulties with living documented of others in this diagnostic category.

McCreary, Turner, and Dawson (1980) looked at personality traits in 120 chronic low back pain patients and distilled 5 factors which accounted for 71 percent of variance. These were:

distrust and alienation,

somatic concern,

vulnerability,

extroversion,

social desirability concerns.

Similarly, Clark and Friedman (1983) used nine standardized scales for evaluating treatment outcome in a mental health clinic. Factors associated with successful outcome turned out to be: family involvement, involvement with friends, labour market participation, substance abuse, client satisfaction and client goal attainment.

Looking at the mechanics of interaction involving chronic sufferers, Meldman (1970) noted that such individuals typically cannot shift from attendee to attendor status as well as can non-sufferers.

Of course, not everyone believes that psychological factors are pivotal in the generation and maintainance of chronic low back pain. Let us now look at other options.

Psychological Factors as Independent from Bodily Factors

Contrary to the centralist attribution is evidence (Von Bayer, 1981 p.9-10) that differences between improved and unimproved clients on the Minnesota Multiphasic Personality Inventory (MMPI) are absent or negligible. As Leavit (1985) points out, the "Conversion 'V'" on the MMPI, which is widely used in clinical settings as a warning signal of a difficult client, is not

actually useful in differentiating between organic and non-organic clients. Leavitt (1985) suggests that the dynamics of mind-body interaction are similar in both of these groups and that the "Conversion 'V'" myth is merely an historical accident. Merskey (in Holzman and Turk 1986) notes that having actual physical symptoms, whatever their origin, and truthfully reporting them, will give one a "Conversion 'V'" MMPI profile (elevated Hypochondriasis, Hysteria and Depression scales on an otherwise bland MMPI portrait).

In a similar vein, Peltz and Merskey (1982) argue that psychologizing an unfixed problem is a strong temptation for the helping professions and that compensation clients and individuals with organic as well as 'functional' pain problems suffer from very similar difficulties and similar personality consequences. These include problems with work, problems with sleep, with leisure activities, excercise, social activities and sex, as well as the general wearing down of personality resources, so that even previously average individuals begin to exibit adjustment difficulties. This position holds that psychological change is the effect, not the cause of suffering.

Lefebvre (1981 p.18) notes that "Chronic pain syndromes are notoriously refractory to traditional medical treatments ..." and 13-20% of the general population have some depressive symptoms. The claim of a causal relationship between depression and chronic pain is, in his opinion,

questionable.

Looking more specifically at the situation of the compensation clients, Beals (1984, p.233) points out that the term "compensation neurosis" was coined in the 1800s by physicians who observed that "many malingerers had been cured by successful suits at law." As such, an attribution to psychological (involuntary) forces may seem more charitable than attribution to economic (voluntary) ones.

There can be no doubt, though, that circumstances colour the complaint. For example, to the question: "Is there an accidental cause to sciatica?" Claimants in the United States answer yes 92% of the time, in Great Britain 59%, and in Sweden (where support does not depend on the accident relatedness of the condition) only 22% of the time. In another example, New Zealand recently passed a law that the first week of compensation had to be paid at full rate. The one-week disability rate mushroomed.

Beals (1984 p. 235) attributes the problem of chronicity not to psychology but to the legalisms involved, noting that: "Excessively elaborate and irrational compensation rules are providing to the detriment of both injured humans and society." He argues that excessive payments, open claims and easy appeals discourage recovery; that the recovering worker is typically fat, undisciplined, and on drugs; and that unions conspire to keep him off the

workrolls and on compensation to shorten the list at the hiring halls.

The assumption necessary for attribution of chronicity to the inner aspects of the psyche is that the sufferers are somehow wrong in what they think, while the rest of us are right, and more rational. Layne (1983) even undermines this hypothesis by showing that depressives' cognitions are not faulty but, statistically speaking, more accurate than those of the non-depressed. Normals are, in fact, less able than depressives to apprehend the true likelihood of the life disasters about to descend upon their heads. Layne (1983) suggests that childhood traumas prevent depressives from forming the defensive screen which keeps the rest of us insulated from life's realities. Do psychological factors, then, constitute a failure of folly? Is the patient to be blamed for an inability to believe in the toothfairy?

To what degree, then, are we as psychologists involved in unjustifiably pushing psychological issues into the forefront of the experience of physical suffering? Is there a sensible middle ground which defines our role without misrepresenting our importance and our potential contribution?

Integration of View Points

Weighill (1983) reviewed the topic of compensation neurosis (the dependency on financial support which the client substantiates to self and others by claiming a degree of suffering not documentable by objective

means) and described it as a cascade dependent on the flow of money from compensation and ending in claim of continuing pain. While compensation neurosis is generally attributed to predisposing personal factors, post traumatic neurosis (disability caused by a traumatic event which leads to measurable levels of stress and arousal that interfere with normal functioning) is thought to be a condition potentially encountered by anyone. Compensation neurosis is typically seen as maintained by secondary gains such as role definition and relationship maintainance, not neccessarily solely by finances. Post traumatic neurosis is usually not seen as nourished by secondary gains but rather by circular self-perpetuating psychosomatic processes.

Weighill (1983) notes that among accident victims, blaming another and feeling that the accident was avoidable predicts poor coping while self blame is predictive of better adjustment. Perhaps forgetting the connection between lack of education and the need to make a living by physical means, Weighill (1983) also proposes that: "On the whole, patients from less skilled and more poorly educated backgrounds would appear overrepresented among the compensation neurosis cases." Compensation neurosis is considered difficult to treat because passivity and 'lack of motivation' are common client traits. Few 'compensation neurosis' cases with low back problems ever

return to their previous level of occupation, and, perhaps surprisingly, Weighill (1983) found that".. most patients did not improve their psychological state after (financial) settlement."

"Motivation" is often used as a client-attributable explanation of treatment failure. Miller (1985) proposes a dynamic, interactive view of motivation rather than a trait view and asks how to increase the probability of recovery-relevant attribution. Wile (1984), among others, sees psychotherapy itself as an accusatory process, a problem which becomes even more severe when the therapist has dual responsibility or is mandated and paid for by a party other than the client.

An Interplay Between The Situation And Internal States

Diener (1984,p. 542) looked at what is happiness and found that :" ...the happy person emerges as a young, healthy, well educated, well paid, extroverted, optimistic, worry -free, religious, married, with high self esteem, high job morale, modest aspirations, of either sex and of wide range of intelligence."

While happiness correlates with relative wealth of the person within a country, absolute wealth is irrelevant. That is, people were not found to be happier in wealthier countries. A sudden rise in national affluence does not increase the amount of happiness. However, economic downturn creates

unhappiness; the unemployed are typically the unhappiest group. Married people are happier, but those with children were not happier than those without. Controllable events ruin happiness less than uncontrollable ones, and self-esteem drops during periods of unhappiness.

Asking: "What makes depressed people feel worse?" Miralles, Caro,and Rippere (1983) found this to be: solitude, problems at work, problems in general, helplessness and inability to cope, thinking about depression, pity from others, too much work, seeing happy people, and the presence of people in general. Most of these relationships are, of course, interactive. For example, health allows activity, and activity benefits health, and both relate to happiness.

Trust is also a core issue in treatment, and one impinging directly on success evaluation. For the sufferer trust enters into the relationship with the body, the physician, society and the individual's own consciousness, and future fate. Miller (1983,p.14), for example, observed that there is a higher general disease incidence in social isolates.

May (1967 p.8) proposed that even offering a diagnosis undermines patient trust, first of all because the consumer of the diagnosis is typically someone other than the patient, second, because the detachment necessary to provide that diagnosis prevents the therapist from participation in the

sufferer's experience and increases the distance between, and distrust between the observer and the observed.

If the client is convinced that there is something that could be done about the chronic pain, and nothing is done, the client grows distrustful and distant. Sternbach (1974) describes the consequent 'paranoid' position as: "outside forces are responsible for my misery, I must do something." This stance at times leads to speculation by the WCB client on misappropriation of funds by treatment staff, personal implication of global political issues, or interpersonal defensive action including threats of violence, of bombing, and the like. Sternbach (1974) describes the opposite, the 'anti-paranoid' position as: "there is absolutely no sense to any of it, and no matter what I do I cannot influence my life or understand it." This position is even more destructive and less approachable. There is, of course, also the depressive position in which I am responsible for my misery, and nothing can be done because I am a bad or inadequate person.

The clients seen in the Psychology Department have typically gone through a number of previous treatments, each dressed in the appropriate hope- and placebo effect- eliciting setting, and these have failed. As deRivera (1976 p.401) notes, near-success is more frustrating than outright failure because it loosens the border between reality and unreality. The

psychologists are therefore not even free to assume that raising hope is a safe or constructive strategy.

Given that more resistant clients tend to change less and show less congruence with the goals of the agency and less satisfaction (Nouwen and Solinger, 1979), and given that the clients have the right to "...the least restrictive, least intrusive intervention", and that "clients have rights of protection against unauthorized sharing of confidential personal information," (Pettifor, 1985 p.22), and given the unreliability of the client, the participant-observer and of paper and pencil scales, the reader can appreciate that entering and understanding the low back pain experience in compensation requires a unique approach.

The complex interactions between the assumptions of the participants, the realities of their relationships, and the structural limitations imposed by the clients' physical health necessitates a non-partitioning, true to real life investigative approach, and one which remains open to the possibility that many unanticipated factors are simultaneously involved.

B. APPROACHES TO EVALUATION OF TREATMENT OUTCOME

As those involved in evaluating outcome of treatment already know, determining what helps is not easy. Pedro-Carroll and Cowen (1985) point

out that it is much easier to measure achievement of specific goals and teach specific tasks than to determine the efficacy of changing people.

In an effort to make the evaluation of the therapeutic task more 'systematic' Luborsky, McLellan, Woody, O'Brian, and Auerbach (1985) first trained the therapists to work according to explicit manuals. The sessions were taped and evaluated to see how closely the therapists conformed to those manuals. While capable of telling us the degree of compliance to some theoretical ideal, such an approach is clearly impractical here because, for one thing, no reliable standard of success exists. For another, the agenda and the goals must primarily derive from the client or the client will simply not cooperate or even come back.

In the WCB setting an agreed upon yardstick of success is lacking. The clearest possible measure would be "return to work", "independence from Board support", and a "return to a pre-accident state of mind."

"Return to work", does take place in the vast majority of Board cases. But it is "non-return" which brings the client to the Rehabilitation Centre, and then, to the Psychology Department. Though an undeniable sign of success, return to work (or "RTW" in bureaucratese), is perhaps misleading. For one thing, in Alberta, an employer is not forced by law to re-employ an injured worker after rehabilitation is completed. A worker, 20 percent disabled, may

be 100 percent unemployable in a cooling economic climate. That client constitutes a complete therapeutic failure if return to work is the only criterion. The worker may also be heading for academic re-training or upgrading to qualify for a different position and still be considered a failure if RTW is the only marker of success.

To maintain perspective in the domain of the problem of therapeutic success, Shoemakerm , Cox, and Bizaillon (1986 p. 1) propose: "Chronic pain patients, particularly 'low back losers' following a work-related injury have been extremely difficult to rehabilitate." As we saw, these authors suggest that since the majority of such clients are unreachable, research should attempt to identify the small minority who can be helped at all.

An innapropriate transplant of standard psychotherapeutic assumptions may, indeed, exact a high price. First of all, to quote William Feather, (in Flesch, 1957 p.178): "When a man needs money, he needs money, and not a headache tablet or a prayer."

Secondly, a traumatic experience is not necessarily ameanable to intervention, no matter how high the quality of that intervention may be. In a related discussion Tucker (1981) showed that unilateral barbiturate injection into the dominant hemisphere (which depotentiates that hemisphere and its reality-contact function) brings forth a whole integrated world view of

futility, depression, and mute despair. It would certainly be tempting to speculate that after years of exposure to defeat and chronic pain the state of doom (represented in the non-communicating non-dominant hemisphere) is unshakeable, and stays in place despite the client's adamant claims that he wasn't always like this, and that he doesn't want to remain this way.

When we look at examples of victims in a structural collapse disaster, (Wilkinson, 1983) we see that the injured victims, guests, and rescue workers all suffered various degrees of psychiatric symptoms including repeated recollections, sadness, fatigue, and guilt (because they lived and others died, because they had not helped enough, or because they brought someone to the hotel who died). Anxiety, depression and anger were the most common complaints among these individuals. Again, the point is, psychotherapy may help cope with experience within the pale, but we cannot assume that psychotherapy can overcome the truly extraordinary, or that it can roll back time. No matter what our faith in psychological intervention, few of us would see it as a wand that dismisses all human pain and tragedy.

Another difficulty in setting a standard for success in therapy has to do with the issue of temporal perspective. The client experiences a particular point in time, not the whole of existence. When we ask about a client's present state we focus in on the vulnerability and suffering here and now, and

depotentiate whatever charms psychological intervention may have put into place by evoking the long-term perspective. Thus Pennabaker (1982) in looking at evaluation of treatment effectiveness proposed that measuring a phenomenon alters it, and asking the patient about sensations focuses on the very things we wished to be rid of.

Perhaps therapeutic success may resemble Joseph Conrad's observation: "I remember my youth and the feeling that will never come back any more - the feeling that I could last forever, outlast the sea, the earth, and all men" (in Flesch, 1957 p.323). But how do we return a person to invulnerability, and then assess its durability without undoing our efforts?

Commenting on this point, Quattrone (1985) observed that actions can change while the subject denies any change in beliefs. It may be that change in behaviour erases the preceeding internal state. The person who improved has become different and may no longer recall what his chronic pain experience was really like; and change therefore may not be accessible by subjective means.

The more cynical have, in any case, had their suspicions about self-report among the suffering: William Osler (in Murphy, 1981 p.30) proposed: "I was thinking of my patients, and how the worst moment for them

was when they discovered they were masters of their own fate. It was not a matter of bad or good luck. When they could no longer blame fate, they were in despair."

Another problem in the area of self-report has been alluded to by Bateson (1978) who points out that a display presented as display is perceived as not real. With low back pain clients asked to repeat the same story many times each day, the presentation loses spontaneity and becomes a display. The question of whether it is 'real' or not then depends on the charity of the listener.

Sarason (1981, p.17) explicitly states that psychological theory is useless to the practitioner. One reason is that academic psychologists believe, on the whole, that things ought to be done through conscious actions of the social order and that they assume a pseudo-world of self-aware, verbal, left hemispheric adults, and that this is not the whole world. Such a conscious, rational, 'nice' world is certainly not the place of chronic low back pain clients on compensation. For example, Bakal, (1979, p.94) notes that it used to be assumed that giving the client a great deal of information before surgery leads to better recovery. This is not actually the case. It also used to be thought that public education about health matters will automatically have positive results. This is not necessarily the case either. For example,

suicide rate increased measurably following the establishment of a widely advertised suicide prevention centre in Los Angeles (Bakal 1979, p.133). This again points out that the effects of directed, conscious action, no matter how well meant and how compliant with the current belief system, must be evaluated before it can be accepted.

C. HOW THE PRESENT APPROACH SUPERCEDES THE USE OF STATIC SCALES AND MEASURES

The inappropriateness of standard assumptions under field conditions was illustrated during an effort to assess efficacy of the Psychology Department when it was established. The administration considered a number of routes, including, (against strenuous protest from the author who was then the sole clinician), pre-and post MMPI's, depression inventories, and state-trait inventories on each client. Obviously, clients, who don't want to be there in the first place, who resent psychological attribution and suspect they will be cut off benefits if they appear 'irregular', were not enthused about participation in such an effort. In fact, even the more cooperatively inclined find personality tests intrusive and alienating.

On the question of treatment outcome, Clark and Friedman (1983) similarly note that some of the objective scales in general use are hard to

utilize because people get upset when questioned, particularly about legal difficulties and drug abuse. Open-ended questions, on the other hand, can consume inordinate amounts of time and contribute little that is related to agency goals.

A more promising direction for real-life understanding is offered by DeWitt, Kaltreider, Weiss, and Horowitz (1983). This involves construction of a core conflict hypothesis for each client from which specific change evaluations can be made. The model proposes individualized criteria for improvement which are patient-specific and defined at the outset of therapy. The approach deserves some respect for its acknowledgement of complexity of the issues. However, the authors report that it fails in inter-rater reliability.

In an effort to get away from irritating pre-set scales Slavney and McHugh (1985) describe the Life-story method which has some advantages, as well as more real life implications for therapy. Its shortcoming, again is inter-rater reliability and inappropriateness as a base for hypothesis testing.

Emotional stance is, itself, communication, and can be an instruction to others to help. Treatment success in this sense can mean that the patient stops instructing. Teasdale (1985) similarly shows that depression about

depression is an important factor in maintaining depression. What is more, a complaint of pain is not necessarily about the body (Szasz, 1957 p. 101). If it isn't about the body as the physician knows it, it will be rejected. Pain then becomes the symbol of rejection, and the continuing complaint can take the form of aggression. Are we then able to separate actual improvement from mere resignation?

The urgent need for meaningful evaluation in this region of applied psychology is amply demonstrated by the diverse and contradictory nature of viewpoints, models, treatment approaches and measurement techniques presently employed. That need is also demonstrated by the sheer number of unimproved people suffering with chronic pain. The approach used in this thesis needs to accomodate not only all these considerations, but also to fit into the assumptive world of the setting, and of the institution in which it will be judged. But principally it needs to be meaningful in, and true to, the very complex living situation. This method is described in the next chapter.

CHAPTER 3

THE METHOD

The Question

What can compensation psychologists tell us about success and non-success in treating individuals with chronic low back pain?

A. The Subjects

The direct subjects of the inquiry were the seven psychologists of the WCB Psychology Department. These six men and one woman were all Alberta trained and certified, two at the Ph.D., and five at the M.A. level. Six received their training in applied areas, one in social and experimental psychology. Their experience in the field ranged from 1 to 16 years, with an average of 6.5 years. Their experience at the WCB Rehabilitation Centre ranged from 6 months to 6 years, and averaged at 2.85 years. They had from 0 to 12 publications and presentations per year, with an average of 3. Since the wages at the WCB are slightly below provincial hospital standards, and working conditions slightly exceed those standards, and since vacancies are filled from open competition, these psychologists can be assumed to be representative of the provincial standard.

These psychologists deal with clients who are brought to the

Rehabilitation Centre only when treatments available in the community fail to lead to improvement. Typically, these clients undergo physical therapies at the Rehabilitation Centre before being referred to the Psychology Department for individual psychological intervention. By the time they encounter the psychologist, the clients are, usually, graduates of a long series of personal tragedies. Most of them are not self-referred, some are reluctant to come, and some see a referral to the Psychology Department as an accusation.

The clients often arrive with an extensive medical evaluation indicating an absence of structural problems and yet report disabling pain. In consequence to the lack of structural documentation these clients often face limited financial support from the compensation system. They present a human story, a story which is typically coherent and convincing, and without exit.

Sometimes the psychologist sees the client improve. Sometimes there is no resolution. The questions asked by this study are, then, what is the nature of the situation? How can the diverse views of the psychologists be reconstituted and explicated? What psychotherapeutic assistance is being offered? What are the described features of successful and unsuccessful psychological intervention?

B. Data collection

(This aspect of the method will be discussed again, in greater detail and with examples, in Chapter 4).

Interviews were conducted with the seven WCB psychologists. Each was asked to describe a low back pain client who was particularly successful in treatment: to describe what the client, the compensation system, the family, and the psychologist did, what happened, and what made the difference. Each psychologist was then asked to describe the opposite type of client, one who was perceived as unsuccessful, one who failed to improve, and the psychologist was asked to provide similar relevant details.

The initial tape-recorded interviews were transcribed by me, and I then interpreted the text and condensed it. The accuracy of these verbally condensed descriptive statements was then confirmed with the interviewees. An utmost effort was made to remain loyal to both content and surface structure of the original material (Faltin, 1973).

I then derived themes from these condensations, and again confirmed them with the subjects. (The themes, and indication of their source interview, can be found in the Appendix.) I then combined all themes for successful clients, those for non-successful clients, and those which were

common to both, and arranged these in descending order of frequency. These themes were then cast and recast by me, until comprehensible groupings of themes relating to success and non-success emerged. The psychologists were then re-interviewed regarding procedural specifics, and the accuracy of my understanding and a representation of each case was confirmed.

C. Data Interpretation

In trying to identify and understand the central issue, the point where the client success or non-success is recognized, we must employ a method which will be truthful, and which will remain open to the full range of information we are likely to encounter. As noted in Chapter 2, the needed information is not directly accessible from the client. The client, interacting with a functionary of the compensation system may, in addition to previously cited complications, also have a score of private goals in mind which would skew the portrait of what occurs. This would be the case particularly in situations where success based on psychological treatment is seen as proving that the original complaint was imaginary.

Accurate information about what happens is not available in uncontaminated form from the host organization either. Nor is it, obviously, available from an experimental research strategy if we want to remain

faithful to the myriad of factors, internal, external, situational and physical which exist in this maelstrom.

A viable methodology must skirt not only imbedded interests, and the partition of the phenomenon, but also excesses of scholasticism, by asserting what Merleau-Ponty (1964 p.50) calls the doctrine of "phenomenological positivism" that is, the primacy of fact, of what is, over what is logical or what is accepted.

In deciding on this method of asking participants to describe what they perceive, I side with Papert (1973) by assuming that rigor arises from creative imagination and sound knowledge of the scene where events occur rather than from statistical manipulation. I also assume that meaning is the uniting element in real-life events. Meaning and coherence arise from life itself, not from its partition or from the manipulation of its components. (Dilthey paraphrased by Kockelmans, 1967).

It could be argued that the most directly contrasting methodology, that of natural sciences (which typically place subjects into artificial circumstances) is not applicable to questions involving consciousness, because there is no statistical means of looking at a phenomenon which is aware of itself, aware that it is being studied, and aware that its circumstances during this time of being studied are artificial (Merleau-Ponty,

1964, p. 59). Further, it can well be argued that manipulative research methodology is unsuitable for finding out what happens to low back pain sufferers in psychotherapy because of that methodology's narrowness of focus. As DeRivera (1976 p.25), White, (1954, p.3) and Anderson (Anderson, 1983 p.18) point out, the proper unit of study in 'real life questions' is not a behaviour, or even an individual, but the individual-in-a-lived-situation. I may even add to this: ' as described by many observers over time,' which brings us to the evolution of the method used in this thesis.

As already noted, this evolution began with Husserl's dictum that it is the Lebenswelt, the living world, which grants meaning to events that occur in it (Kocklemans, 1967, p.20). The method is also an outgrowth of the thoughts of Merleau-Ponty (1967) and Bain (1987) who argue that perception does not take place in a vacuum but is, rather, perception OF SOMETHING, and that, therefore, interpersonal agreement is a meaningful concept.

The method is also related to aspects of Slavney and McHugh's (1985) life story (or "deep structure") method of describing therapeutic change, and to Mannon's (1985) method of describing the recovery of burn patients. It also draws on the real world work of Palmer (1983) who describes the lives and coping strategies of paramedics, and finally on the words of Victor Frankl (1984) who justifies working from within a situation thus: " ... does a man

who makes his observations while he himself is a prisoner possess the necessary detachment? Such detachment is granted to the outsider, but he is too far removed to make any statements of real value. Only the man inside knows."

The present method adds the reconstitutive, triangulative aspect by first seeking repeated zeroing in on a complete description with each separate subject, and then seeking an integration of views of all the subjects about the topic they perceive, interact with, and describe. This multi-stage reconstitutive method was devised by Bain (1980-1987), Vanderwell (1985-1987), and myself. It is specific enough, and flexible enough (see example in Chapter 4) to be also useful in other settings.

Formalization and model building were never the goals of this thesis. I am in agreement with Hofstadter (1979, p.93) and Sartre (1969 p.52), who argue that there is only a tangential relationship between formal thought and complex living experience.

It is assumed here that the goal of science, whether empirical or phenomenological, is to generate a progressive understanding and description of our living experience. Of course, phenomenological methods have limitations. These methods cannot assure that insights reached are complete, and even lack a formal way for deciding on the relative validity of competing

insights (H. Jonas in Carr & Casey 1973 p.107). Phenomenological methods do, however, offer an accepted means of proceeding

A sufficient description of the phenomenon itself is achieved by 1) describing the situation as it appears, and declaring one's position and pre-existing stance, 2) putting aside the existing attitude and goals of the researcher and allowing the often contradictory viewpoints of the subjects to take centre stage, 3) triangulation: varying the horizon imaginatively, to see if the conclusions arrived at are sensible in other circumstances (in this thesis there is the added feature of repeated confirmation of the product of each procedural step with the original subjects), and 4) interpretation of meanings as they emerge (again in this case confirmed with the subjects) (Keen 1975, p. 38). To this basic requirement is added the feature of a numerical check of frequency of occurrence of central themes in the interviews to identify common specific occurrences across the divergent viewpoints of the subjects. (Procedural specifics are described again in detail in chapters 4 and 5).

According to Churchill (1985) the measure of a sufficient phenomenological description are Zusammenhang (hanging together), and external validity. The 'hanging together' in this thesis can only be judged by the reader, and must rely on the reader's own sense of closure. In this thesis

external validity was verified through the repeated checks of correspondence between the material and the opinions of the interviewees. As we shall see, that process of confirmation leads to differences of opinion and these differences themselves provide a rich source of information.

I, as the participant interviewer am not an independent, detached observer in this situation. I am not only the gatherer and editor of the material, but also a working member of the Psychology Department. My viewpoint is, unavoidably, familiar to the interviewees from years of daily interaction, however, my own struggle with these questions, and my own lack of closure, is also clearly known to them.

Chapter Summary

This chapter outlines the method used for generating from psychologists' interviews a description of their understanding of what does and does not help in psychotherapy with end-stage chronic lower back pain sufferers. Subjects, and the processes of data collection and data interpretation are described and alternate approaches to the research question are examined.

CHAPTER 4

DATA

The Question

What can compensation psychologists tell us about success and non-success in treating individuals with chronic low back pain?

The reader will recall that no specific definitions of success and non-success were established. The decision about what kind of case best represents which category was made by the interviewees individually, and thus the gathered material addressed not only specific case information but also their viewpoint and experience as a whole.

A. THE PROCEDURE OF DATA COLLECTION

The seven psychologists in the Alberta Workers' Compensation Board Psychology Department were interviewed by the author. Six of the seven psychologists provided descriptions of successful cases (one providing two such success descriptions). One psychologist had not experienced a success memorable enough to report and therefore reported only two non-successful cases. As a result there follow reports of seven successful cases described by six of the staff psychologists. There also follow reports of eight non-successful cases described by seven of the psychologists. The

description of how these results were summarized, and the initial findings, are the subject of this chapter.

To review, the stages of the method were:

1) The initial interview with each psychologist centered on a description of therapeutic success and non-success with long term low back pain clients. Each interview was followed by specific clarifying questions until the interviewer was satisfied that the portrait offered seemed complete.

2) The interviews were then condensed to essential core descriptions.

3) The descriptions thus identified were then used to build a composite portrait for each case.

4) These core portraits were reviewed by the interviewee to confirm accuracy and completeness (they are presented in this chapter).

5) All core descriptors dealing with success were then combined, and so were the descriptors for non-success. Descriptors common to both success and non-success were also combined, in a separate category.

6) These groupings were then subdivided into themes (such as social influences, therapeutic approach, client response to own body etc.) and these were further integrated and interpreted into comprehensible groupings about what was or was not effective. Further integrations can be found in Chapter 5.

The reader will recall that the nature of a compensation board demands that judgements be made about the compensability and non-compensability of injuries, and that in the vast majority of chronic low back cases clear physical documentation for the disorder is absent. As a result, an adversarial atmosphere sometimes prevails. Even without that, it would clearly be unethical and a breach of several levels of confidentiality (between the client and the psychologist, as well as between the reporting psychologist and myself, and between the compensation board and myself) to present identifiable client descriptions in this thesis. However, it is also important that the reader be able to follow the steps involved in this reconstitutive hermeneutic procedure. For that reason, let us look at a fictional case description which is similar to many actual cases. It is also similar in language to the actual interview content because the psychologists were asked to describe the cases in plain language, and without any reference to psychological theory.

The Fictional Client Alf

"Alf was brought to my office by his Vocational Rehabilitation counselor who said that something had to be done because Alf was not cooperating with vocational placement and his compensation payments were likely to be

reduced because there were no structural findings documenting his claimed back pain. Alf was so angry he could hardly talk. First of all, he didn't understand what was happening to his claim.

He was a mechanic for many years and then ran his own garage that had burned down, after which he went to work for a car dealer. He was taking a car for a road test and stopped to make some adjustments under the hood when he was hit by another car. There is a third party lawsuit in progress and the financial implications are unclear, but the main problem is that Alf felt he did the honourable thing and went back to work for as long as he could, and then, two weeks later, because he couldn't even get out of bed any more, he had trouble convincing people that his problem had to do with the road test accident.

"In any case, he wasn't able to work for two years by this time, and there was never a solid diagnosis, except for back spasms, and he still had a lot of pain after any bending and walking and effort. In the meanwhile because of the interrupted employment record, compensation money was tight and he had perpetual arguments with his teenage kids, and finally the wife took the side of the kids and it became a question of separation or divorce, but since they couldn't afford two households, Alf ended up living in the basement, almost as a tenant.

"At the time I first saw him things didn't go well. He was sleeping two hours a night, and roaming around the house the rest of the time. Though coming to psychology was not his idea, he kept on showing up but he wasn't sure what to expect or how to behave or how much he could yell at me. He saw some brochures by the secretary's desk and eventually asked about the relaxation training group, and joined it.

"We got him started, and that includes a lot of excercises in visualization and sleep induction. Unfortunately, his wife had started working nights at that point, and another of his teenage kids was let go on the pipeline for drug problems and moved in back home. I suggested that Alf bring his wife for a chat so we could separate the personal issues from the stress and pain issues and arrange things more reasonably at home, but it could not be done. What happened instead was that Alf began sleeping better and felt more able to do some of the physical excercises in the process.

"In the meanwhile, the vocational rehabilitation counselor came by with a part-time security job, and a wage supplement, as a stop gap before deciding what to do next. I think if that had happened two weeks before, Alf would have hit the roof, since he had so much expertise in mechanics and running his own business, but now he saw it as an opportunity in several ways. One was that it put him back on a regular schedule. The other was that

the family would see he was serious about getting back to normal. After two years in the basement, living on painkillers, he needed to show them that.

"Another reason he took the opportunity was that he saw some biofeedback equipment lying around in the relaxation room and asked about it and I got him walking around with an EMG practicing how to keep the spasms under control, which he did well, and he went on to try it in the real world.

"So Alf took the job, and it was hard at first to stay on his feet, but it really brought him up when he realized he could survive a week part-time. The people from the accident employer (the car dealer) had been trying to talk to him all along but he'd always chew their head off about how it was their fault that he was a cripple and they thought he'd turned into a flake. But now that he had a job again he started going out for beers with a few of them and eventually they decided that he could also have a two day per week position with them ordering parts and doing some book keeping.

"Alf kept coming back for several weeks after that, trying to figure out what it all meant, and how to keep up his morale it he became disabled again in the future. The last time I saw Alf he was in that position, not really all the way back job wise, but not doing too badly, still living in the basement and on a different schedule from his wife, but getting along with some of his kids. But the important thing as Alf saw it was that he had the problems

separated out, and though he couldn't control all of them, he had some sense of what to expect from day to day. Personally, I think that the stress reaction he was experiencing when I first met him must have been horrible. He was emotional, either crying or in a rage, he couldn't remember anything, he was on all sorts of drugs and now he had cut that down too. So, he regained some control, and he says he feels human again and he is at least not afraid to hope for better. He tells me he'd like to get his own place of business again, a clearing house for used car parts, and for all I know he may well do that."

After recording and transcribing an interview such as this, I returned to the source to clarify remaining questions. These may include asking whether the marital relationship was reported as satisfactory before the accident, the psychologist's recalled feelings toward Alf at first contact and at discharge, Alf's apparent change in relating to other clients, his physical carriage and general world stance, the particular sequence of events which lead to improved family relationships, and the like. However, it was not usually necessary to make the inquiry too specific.

When this stage was completed, the written material was reduced to constituent descriptive themes. These may include, from the above fictional example:

Social relationship, compensation and pain problems at start of treatment

Client not self referred but related well to psychological services

Client had a good work history

Client had been in his own business

Client liked pre-accident job but now saw self as unemployable

Client worked for some time after the accident until disabled by pain

Problem with stress and drugs

Good therapeutic relationship throughout

Vocational clarification occured before discharge

Spouse relieved financial strain by finding employment

Client sought out additional treatment modalities

At discharge client was working up to the limit, up to the point of pain

Successful education about stress and body function occurred

Better social relationships, relaxation and sleep at discharge

-plus many other descriptors like those which the reader can find in the Appendix.

In the next step these descriptive themes were combined into a

paragraph which was to be comprehensive, yet not identify the specific individual. The source psychologist was asked to read that paragraph and comment on its' completeness, and add to it if necessary. That accumulation of descriptors then formed the basis for the summaries and interpretations presented in this chapter. When these summaries and interpretations were finalized, they were also reviewed by the source for completeness, coherence, and adherence to the important aspects of the original case.

Finally, in a separate procedure, the descriptive themes of this case were combined with those of other successful cases and all were then treated as a pool, which was subsequently divided into topic areas which are presented in the latter part of this chapter. Examples include: THERAPEUTIC RELATIONSHIP, WORK ISSUES, SOCIAL INVESTMENT AND RELATIONSHIPS, BODY RELATIONSHIP, SELF RELATIONSHIP, COMPENSATION ISSUES, MEDICAL ISSUES, THERAPEUTIC PROCESS, and the like. All the gathered information is further integrated and interpreted in Chapter 5.

B. CHARACTERISTICS OF THERAPEUTIC SUCCESSES:

CASE SUMMARIES

These summaries were constructed from descriptors deemed relevant to each case. The interpretation of each case was discussed with the psychologist involved and this input was integrated in the final

interpretation.

Case 1

Summary: A young labourer suffers a painful injury and fails to find physical resolution, a sympathetic ear, or sufficient financial support from the Compensation System. He meets a psychologist who resembles him in socioeconomic history, and this psychologist helps him to adapt to his circumstances without the overt hostility which was part of his previous existence. A physical resolution arrives coincidentally.

Descriptive components: The client claims he was in good pre-accident physical condition. At the beginning of contact he appeared as an independent, assertive, pseudo-socialized outsider with a low level job and in conflict with the compensation system. The client was fed up with being reassured and with numerous failed medical treatments and was physically self-protective at the start of contact. He had failed to improve under standard medical treatment he had been blamed for the problem, and resented it. The client wanted out of the low back pain situation and was willing to accept psychological treatment.

The client learned to use biofeedback techniques, he liked the relationship in therapy, the ventilation and the educational component. He was

clearly in charge of the therapeutic relationship, and used it to learn specific skills and techniques. There was a good initial psychologist-client relationship and mutual affection at termination. Reinclusion in social interaction occurred and the psychologist was a major part of that process.

Vocational clarification took place before resolution, with the client going on to a lighter, physically less strenuous job. The client accepted some remaining pain and worked through it. At discharge he was willing to meet the future without guarantees and was different in his presentation, more communicative, capable of more spinal flexion and extension, looser, and physically less guarded. He also changed his social interaction style and began to communicate his difficulties and emotions with the therapist and with those others whom he had begun to trust.

Case interpretation: This was the only client in the study whom I have personally met. I saw him for thirty three hours of individual biofeedback training to overcome paravertebral spasms and assist him to normalize bilateral hip use. I can say that he was the most frightening individual whom I have encountered. His decision to re-join society seemed just that, a decision reached on the basis of plusses and minuses. I didn't sense that he experienced restraints and obligations as other people do. Despite his well

documented potential for causing major physical harm (i.e. death) to others, he was an interesting fellow, even obliging in some situations. For example he volunteered to star in a videotape that helped bring hope to other clients who could, because of his unmistakeable body carriage and attitude, tell that his description of improvement and his message of hope in recovery was absolutely genuine.

During the long hours of biofeedback practice in the lab he shortened the time with stories of extraordinary complexity, mostly centering on prison life. The psychologist also experienced the intimidation posed by this client's presence. The client could not be confined in a place, a school or a relationship unless he found something of immediate value there. Though this client came from an exploitative and threatening environment, and though he seemed always alert to potential dangers around him, this did not appear to take a particular toll on his body in that he appeared completely relaxed even in difficult interpersonal circumstances. However, from his description and from observation of 'bad days' it was clear that the presence of intense and prolonged low back pain did take its toll.

The client tried to retain some bodily flexibility despite the pain through the use of alcohol and drugs, without much success. He was never burdened with the notion that society would do for him; that someone would provide

care and support and help him in his times of need. He pursued his case with Compensation not in the dim fury of betrayal of social contract but with a smirk. (His financial support was limited because structurally he was without evidence justifying his subjective complaint). Even this detached and controlled individual was eventually turned to outrage by the bureaucratic machinery.

Under more normal circumstances this individual was two things at once: an anathema to a bureaucracy, and the ideal client for a psychologist. He was entirely free with feedback to the therapist regarding the effect of treatment techniques, particularly with biofeedback. This client seemed to be driven almost entirely by personal convenience and inconvenience. His request of the reporting psychologist was, in effect, to be taught the mechanics of normal cooperative social interaction so he could use them to get things done. This was excellently accomplished and coincided with or resulted in general improvement and led to eventual independence of the client from the compensation system.

Case 2

Summary: A frightening, violent man wants help in learning to live normally and to give up the power to intimidate others. He subjects the therapist to his worst guilts and nightmares, the therapist endures, and the

client rejoins family and society.

Descriptive components: Initially independent, assertive, skeptical, this client saw himself as a misfit. He sought individual therapy and was an enthusiastic participant. He had had experience of severe social transgression and wanted to confess. Despite previous therapeutic and social rejection he still wished to communicate, and he received the opportunity. The psychologist was initially reluctant to witness the self-exploration because the content was too frightening and violent, but both persisted despite that reluctance. The client feared his violent impulses and was keen to learn how to keep himself in control.

Future job clarification occurred during therapy which resulted in the client finding lighter, more physically plausible employment. His spouse found a job and relieved some of the financial strain. Eventually a good therapeutic relationship developed and the client allowed himself more faith to succeed in the world.

Initially, the client had difficulties accepting his limitations and disability. No major compensation problems as such were identified by this client. At discharge he was willing to meet his future without guarantees and he was very different in presentation, cheerful, smiling, communicative,

and more mobile. He was keen to do well in the world, and eager to be accepted. Successful re-education occurred regarding eating, physical activity, endurance, and weight loss. The client won an important family confrontation during the course of therapy and learned to integrate the changed approach into his life strategy.

Case interpretation: Though this successful case also involves an 'outcast', this client's sense of shame, his need for re-inclusion and his attempts constantly to threaten others made him somehow more human than the previous client. This client seems to have terrified the psychologist not to be manipulative, but for genuinely confessional reasons, and the completion of the cathartic procedure granted him re-entry into society. (His reports of personal trauma and culpability were experience-based and difficult to bear for the therapist as well as himself).

The client also underwent surgery during this time, which allowed him, through the surgeon, to excercise his willpower over the rebellious low back, and re-incorporate it into his body. Another possible benefit of the surgery, in addition to physical improvement, was legitimization of his differentness from other people. Following surgery the client no longer had to enter every potentially painful action with the dread that his pain would be disbelieved

and that he would be confronted with the accusation that his fears were unfounded and his complaints untrue.

Previous to this legitimization the client seemed prone to depotentiate the world through intimidation and insult, and the world did not tolerate this well, particularly from someone who had already transgressed. The client therefore oscillated between 'I am in', and self examination and knowledge of separateness. (This client's transgressions were as severe as those of client number one, but were committed in situations of reduced legal culpability.) The client, on guard against his own hostility and against his sexual and affective strivings, was perhaps by necessity guarded.

The elegance of the therapeutic intervention lay in the ability of the psychologist to suffer through the dreadful confessions and grant the re-entry which depotentiated these efforts and oscillations. The psychologist listened, endured, and did not become angry or disgusted or excessively self-protective. This seems to have led to a profound relational shift for the client which then transferred to spouse, community and finally acceptance of himself.

Case 3

Summary: An immigrant suffers injury and pain, and he despairs. The therapist helps him, with step by step encouragement, to return to his

previous niche in life.

Descriptive components: Initially this client saw the world as demanding too much. He described a high pre-accident income leading to large financial commitments, his English was poor and he suffered family relationship problems when he became disabled. The client did not accept his reaction to extended pain and had a poor understanding of his body.

The client initially did not respond to therapeutic initiatives. The lack of any vocational alternative eventually resulted in his return to his pre-accident job. He reached an acceptance of some remaining pain and the realization that this did not signify progressive disease and was a matter to be tolerated rather than erradicated.

The client was in good physical condition at the start of treatment despite his problems, and worked through much of the physical pain. He had no specifically attributed compensation problems (such as perceived injustice in the amount of award, mishandled cheques or the like) despite limited amounts of money from compensation. In therapy successful re-education took place in areas including physical activities, endurance, and weight loss. Charting and documenting his state of being and progress also seemed to help. The client eventually accepted medical assurance that

activity would not cause additional structural damage. Mutual affection between him and the psychologist existed at termination. The role of the psychologist seemed mainly to educate, to guide, to listen to alternatives, and to support the client in times of fear.

Case interpretation: The declaration of fear can be a gesture of abandoning of responsibility, the failure of all one's efforts under duress, or an appeal for outside help. The people around this client grew weary of his pleas and came to see them as a form of manipulation. The client saw his pleas as means to assure his future and his fear was a response to the world demanding the impossible, while denying that its demands were impossible. The psychologist apparently turned the pleas into a program of self-development.

While the client was aware of his obligations, he over-emphasized his limits. In therapy the focus of attention returned to immediate and resolvable matters dealing with daily living and family relationships. The psychologist managed to guide this shift by meeting him on his own ground and enlisting his cooperation, without raising his resistance to improvement. The client's satisfaction grew when he realized he was approaching a pre-accident level of functioning despite his pain, and could return to his

former socio-economic position.

Case 4 (a)

Summary: A man endures long-standing pain problems and is told that nothing more can be done. He then grasps onto psychological treatment, and does very well.

Descriptive components: This client was part of a close-knit community. Despite having tried everything he could think of and being assured that no other medical procedures would help, he persisted in wanting more medical treatment. His family was cooperative with the psychological treatment program at home. The client had been in the Rehabilitation Centre on a number of previous occassions, but due to lack of structural substantiation he received an amount of money from compensation too low in his opinion for his degree of suffering and disability.

The low back pain was a long term problem for him. By the time he encountered the psychologist his whole life had derailed. As a result of the calming and educational role of the psychologist he learned enough about body mechanics and the cause and effect of his emotional responsivity to work through the pain on a novel basis. There was successful re-education in regard to eating habits, physical activity, endurance in standing, walking, and

physical activity and weight loss. The eventual change that took place was like a religious conversion; a reframing to a more positive attitude about life as a whole. The client continued weight loss and other programs even after the end of therapeutic contact. From a dependent 'let someone else fix it,' the client moved to a clearly more independent self-help attitude.

Case interpretation: The client continued to believe he is loved and cared for through his suffering. Any cure might signal the end of commitment by his family, and the end of his financial support from the Compensation Board. The client thought he was caught in an artificial circumstance and was unwilling to rock the boat. He felt entitled to nothing and could not let himself relax, float, waste time, and had to be in charge of all he did, from body carriage to social presentation. Since he could not get what he wanted, he wished all those around him to be as sad and constricted as he was. The psychologist did not respond to this wish and managed through allegiance, persuasion and modeling of an alternate attitude, to change the client's state. The client, after a 'religious-like conversion' to more a trusting stance stopped his over-dramatic presentation, he relaxed his body and began winning by seeing what is in the here and now. He opened himself to the more positive aspects of the future, and became responsible for his actions and for

the scenarios he chose to consider for himself and which he allowed to dominate his emotional landscape. Success in control of the physical domain, of excesses in eating and self attention were key aspects of this successful outcome.

Case 4 (b)

Summary: A man struggles to keep his job despite his pain, but has to give up, and loses everything. After hitting bottom, and with the help of the psychologist he works his way back up.

Descriptive components: The client worked for some months after his accident despite backpain, until he could not, then applied for compensation. In subsequent months he lost his possessions, suffered financial strain and encountered family relationship problems. Physicians told him he would not work again, and this ironically motivated him to action and participation in some non-physical therapies. Despite some success he became depressed again as no work was available. Then a new vocational opportunity encouraged positive mood change.

In treatment the psychologist introduced biofeedback and encouraged return to physically active therapies. The client had many previous experiences of ups and downs in his life. He had the experience of being

self-directing, including running his own business. Again the change was like a religious conversion, a reframing to more positive global attitudes and behaviours. This was once again lost, but the client recovered following physical improvement with the help of chiropractic intervention.

Case interpretation: This client may be atypical in that he admits to experiencing extreme emotional highs and lows previous to the compensable accident. The cycles which occur while he is in therapy may therefore be attributed to indigenous mental or biological predisposition. This does not, however, under new legislation, have an effect on the legitimacy of the claim. In any case, few people, regardless of predisposition, can overcome the adversity of such dire circumstances. Through the changes in fortune the psychologist was there, pitching for the positive outlook and outcome, and providing a ground on which the client's improvements could be based.

Case 5

Summary: A well integrated sociable woman suffers an injury which interferes with her life. With the psychologist's support she recovers control, gets re-involved, and carries on with her life.

Descriptive components: The client was enthusiastic, and sought information on how to get better. She reported she recovered well from a previous low back pain episode and had faith in the psychologist and in psychological intervention. The client liked her pre-accident work. Good family relationships existed, and so did good relationships with Centre treatment staff. The client was part of a close-knit community. Her physical problems were clearcut and activity consistently increased her low back pain. At discharge the client was working up to the limit imposed by structural factors, up to the point of pain. The psychologist's reliable presence, as well as actual advice helped the client overcome a physical setback and cope with the emotional impact of chronic pain and disability.

Case interpretation: This client's problem is documented on compensation files as demonstrably involving a physical component (that is not always the case, and is a factor which changes the client relationship with the compensation system). This client was referred for assistance in coping with the impact of changed personal status. Socially and psychologically this client, in the psychologist's description, possessed solid resources, and did not need the sick role to smooth her future life. The resolution of this case was, apparently, a relatively straightforward one

centering on some basic life issues. Since the client had not improved before seeing the psychologist, there was obviously more to the case. This probably consisted of the opportunity to formulate resolutions, obtain support, and examine feelings, desires and resources in a relaxed and supportive atmosphere of the psychologist's presence.

Case 7

Summary: An apparently rigid and controlled man is angry about being sent to Psychology. The therapist teaches him still more self control through biofeedback, while encouraging greater self-acceptance. The client decides to be nicer to himself and others and self-control eventually becomes less important to him.

Descriptive components: Initially this client saw the world as demanding too much. He had a dispute with the compensation system and planned to travel to distant places to obtain additional medical evaluation and treatment.

When an instructional approach was initially used by the psychologist, the relationship was so strained that the psychologist found it necessary to distance himself from the client. The client presented himself as an independent, assertive, skeptical, and willfully difficult person. He was

physically self-protective and resistant to accepting psychological help, yet returned in subsequent sessions.

In therapy the client achieved a change in his interacting style as well as successful education about his bodily functioning, including use of biofeedback. He then returned to physically active therapies. Charting and documenting his state of being and progress was particularly helpful in shoring up hope. The client was surprised by insights into his own dynamics. Eventually a good therapeutic relationship and faith in success in the world came about. At discharge the client worked up to the limit, up to point of pain, and accepted some remaining pain as tolerable. At termination he ceased his dramatic display of disability and was described as assertive, independent, and self-affirming, and willing to meet the future without guarantees. At discharge he was described as cheerful, communicative, mobile, and able to relax. Interpersonally he was also more disclosing and less controling.

Case interpretation: This client initially alienated those around him. The psychologist failed to react to this, first by being physically absent during biofeedback practice sessions, later by ignoring interpersonal snares, thus not allowing the client to 'mess in his nest', and letting the interaction

continue past this first barrier. The client may well have been as will-oriented, as lacking in subtlety in responding to his body as he was in responding to other people. Here the biofeedback and the more gentle self-regard modelled by the psychologist appeared to have been of value.

Issues like family problems and other private concerns were less accessible to discussion, at least initially, with this compensation client. The client seemed too busy trying to convince others of his viewpoint and to get his goals squeezed into other people's agenda to self-refer or attend to signals of discomfort emenating from his lower back. Simply, he was initially too excited and aggrevated to attend to himself. In this regard the unpredictability and other-worldliness of therapeutic contact in psychology were ideally suited to cause a change of focus from agenda item counting to genuine self access. In addition to describing some useful technique, this case illustrates the need for the psychologist to be able to withstand the initial attack and abrasion without succumbing to an adversarial attitude in order to progress beyond that stage.

C. CHARACTERISTICS OF THERAPEUTIC NON-SUCCESSES: CASE SUMMARIES

Six psychologists each provided a description of a non-successful case,

and one psychologist provided two such descriptions, for a total of eight cases.

Case 1

Summary: An attractive, stubborn young woman set out on her own, found employment and got injured. In treatment she seemed to want to be taken care of, and to be loved and entertained, while the therapist encouraged her to go out on her own and try again.

Descriptive components: The client has a multitude of physical and relationship problems. The psychologist doesn't believe the client's complaint of physical limitations because of a lack of documentation and inconsistant behaviour.

The client apears to be manipulating and does not want the psychologist to try and cause change, but merely to attend. She appears to be going through prescribed procedures only to please the psychologist. The client seems to be trying to prove herself to persons in authority, and is not succeeding. She is seductive, exhibitionistic, and wanting to touch the psychologist. The psychologist switches to an authoritative approach after failure of a less directive route. The psychologist grows to believe that compensation money

and other compensation benefits act to keep the client acting disabled.

Case Interpretation: This client may be locked in a cycle of dysphoria followed by an attempt to bind people to her, followed by a realization of the failure and absurdity of that strategy, and an inability to retreat from it. She may be typical of the clients who always insist on being special in a group: "This will not work on me because ..." etc. She may realize this tactic is transparent to others but seems unable to function without constant individual validation. She may feel entitled to closeness and see distancing as condemnation.

The client may be saying, in effect: "here is my suffering, and that is why you should love me, validate me." The psychologist is essentially saying: "There is nothing wrong with your body, you are sending a false message, and here is how you can come to be in charge of that message."

In her quest for commitment from others the client has little else to trade beside personal affection, closeness for closeness, while the psychologist urges distance and independence. That withdrawal of contact may seem to her a threat. The client has, in these circumstances, no pool of prior trust and obligation to draw on to guarantee a continuation of the relationship and realizes personal intimacy is not a currency here. With

subsequent psychologists her contact is even shorter, and consists exclusively of the initial exposition of her needs. The compensation psychologist's message as to the impropriety of a seductive strategy failed to outweigh its reinforcement elsewhere in her life, from male compensation claimants and from bar patrons. The client eventually chooses to take her needs, psychological and otherwise, outside of the therapeutic arena rather than face further loss on uncertain territory.

Case 2

Summary: A sad, abusive, unsightly alcoholic is dependent on the compensation system and his claim to injured status for sustainance. The psychologist tries to enthuse him about his chances of making it on his own, but fails.

Descriptive components: The client is somewhat repulsive in appearance and habits and he is seen as manipulating in interpersonal presentation. The psychologist doesn't believe the client's complaint and description of physical limits and there is a lack of documentation and inconsistant behaviour about the effects of physical activity and its consequences. The client has had many years of involvement with various compensation boards across the country. He delegates responsibility for improvement to others. He will take

pills and have surgery but will not take part in self-help therapies.

The client does not feel well examined medically and wishes to undergo more diagnostic procedures. His complaints include low back pain, leg pain, poor sleep, and multiple drug dependencies. He is divorced and his current social relationships have problems. He insists on blaming others for his substance addiction rather than trying to overcome it. He alternates low self-confidence with grandiose and unrealistic plans which have no followup in action. He has very limited education, and only low level training and job qualifications.

He has been exposed to the structured pain control program, the therapeutic excercise program, the behaviour modification program, the relaxation training group as well as individual counseling. His understanding of his body is considered poor despite these exposures and his relationship with the compensation system is hostile.

Case Interpretation: This individual has relatively few options in terms of personal charm or sellable skills aside from his claim to injury. He may be conscious of this and may resist the pressure to turn his attention inward because he knows he will either explode and attack, or contort himself in hope of acceptance. He may be better off with no self-reflection but he will

not participate in real-world activity either because again he may face humiliation or because he experiences actual bodily limitations.

Relying on the bargaining power of the injury, he may fail to locate his proper place in the scheme of things, in the pecking order, believing that the claim gives him permission to take up anyone's time at his whim. When this fails, as it must several times a day, he tries to please doggishly. In order to avoid the confrontation with how little he really weighs socially, he may try to be in charge of interactions, avoiding unstructured encounters, or even forcing confrontations, as long as it is in a predictable direction. By siding with the psychologist during group therapy he places himself in untenable positions with his peers and must draw on the therapist's support for self-worth. The psychologist wants him to step away and be independent in the world, at which point the client allies himself with other therapies, or other therapists of perhaps another discipline in order to continue in the present state.

Case 3

Summary: The client suffers, and asks for assistance, but will not join in belief or in activity. A return to the world does not occur.

Descriptive components: The client does not accept medical assurance

that physical activity is permissible despite remaining pain. He attempts to retreat from the world via pension. "No use trying," is his typical response to therapeutic suggestion. The client has been previously treated by psychologists and spent a long time in therapies of one kind or another. He is seen as manipulative. The psychologist doesn't believe the client's complaint and description of physical limits because of a lack of documentation and behaviour contrary to stated limitations.

The client is willing to take pills and have surgery but will not take an active part in self-help therapies, and continues to ask for more medical attention. He comments on the fact that he could have been killed in the accident. He sees himself as severely physically damaged and asks for a full pension (his opinion is not supported by structural findings). He has bizarre somatic convictions which the psychologist cannot displace.

The client does not allow himself to relax even in relaxation training groups, and has not learned to work through pain, and does not follow excercise instructions in the weight room. Re-education in eating habits, physical activity and endurance was unsuccessful. The client does not accept the presence of some remaining pain as tolerable. He specifically mentions being proud of his pre-accident physical condition and disparages of the loss.

Case Interpretation: The client wants to return to the care-free painfree

body that exists in his memory and is meant to represent the pre-accident self. For him to accept himself as he is now, and to work at small improvements, would represent defeat. Fantasies involving the lost self would then have to be accepted as non-real and be abandoned. Faced with such a choice he may be disinclined to take part in interactions with others, but these are necessary for economic and physical survival.

The client may refuse to leave the sick role until he has a guarantee he will be loved despite being an invalid, until he has punished the world enough with his accusations, and until he gets a gift or an apology for what he has suffered. In practice, since this will not happen, he may give up only when he has realized that there is no hope of having his way and that he is the one paying the price. He may, for example, start seeing consciousness itself as a sufficient gift. Unfortunately, when the client does give up his depression and decides to rejoin, he may want his satisfactions <u>now</u>, and demand immediate companionship, sex and money. Since he has lost credibility and since it takes time to rebuild social contacts, another failure occurs, which causes more rage. The client may live a scenario of demands and dependence in which he calls for more service, more devotion, which again fails.

The client sees people around him as tools toward an unclear purpose, and they perceive that they are seen as tools and resent it. The client is

likely also aware of what has occurred, and remembers being different and resents the change that has happened to him.

The client, then, is in a situation where his presence and his affection are treated as an abomination, and while he may get care for ill health, he is not going to earn love by playing the patient role. When he abandons hope and tries to look weak to get financial support to justify and enable solitude he is not likely to be well received.

Case 4

Summary: A foreign-born labourer loses his high-paying job to back pain, and refuses to stay in Canada and try and resolve it. He takes his compensation payment and returns to his country of origin.

Descriptive components: The client had a high pre-accident income, a poor education, and only low-level training and job qualifications, as well as poor English skills.

He had previously gone through the structured pain control program, excercise program, behaviour modification, relaxation training group as well as individual therapy. He liked the relationship and the ventilation in therapy but attempted to retreat from the world with the help of a pension. While he felt dependent on WCB, he did not believe he could be well again and be

independent of it. He desribed sexual problems and masculine role erosion. In his opinion, society owed him more than he is getting. He presents himself as a 'martyr' who sees psychology as a place sheltered from pressure to excercise and job hunt. He has not learned to work through pain, and does not follow excercise instruction. Re-education has been unsuccessful in the areas of eating habits, physical activity, physical endurce and body use, and in the attempt to re-introduce the client to physical therapies and activities. The client saw resolution in getting enough money to start a business, and had a lawyer represent him with the Board.

(The therapist specifically mentioned that the client had a lawyer. Legal assistance, though indicative of an adversarial relationship with the Board, and sometimes its employees, does not automatically suggest poor prognosis for psychological intervention. In discussions the psychologists noted that it is often easier to deal with an adversarial but active and motivated client, than one who is cynical or one who is too depressed to act.)

Case Interpretation: The client may be using fear, which is a vehicle to inspect the future, as a means to escape the present, and he holds the circumstances responsible for this process.

He is a person inclined to believe that the world will not be fair and

accepting, he may expect a negative reaction and to try to neutralize it by condemning his body and his person. Though not identified as a "treatment success" by the reporting psychologist, the client actually works out a practicable resolution in the real world.

Case 5

Summary: A foreign-born labourer loses the capacity for exausting physical work, and loses his belief that anyone can make him better. Failing that, he cannot see life as ever being worthwhile and good again.

Descriptive components: The client has a mixture of several different medical diagnoses, and has undergone a variety of treatments. He has no faith in further treatment, and delegates responsibility for intervention and getting better to others. While he will take pills and have surgery, he will not participate in biofeedback or other self-help tasks. He could be called a treatment addict. At the same time he attempts to retreat from the world via a pension. He feels dependent on the WCB and does not believe he could be well again. The client apparently did not want the psychologist to try and cause change, just to attend. He appeared to be going through procedures only to please the psychologist. While the client initially perceived physicians as being on a pedestal, his high expectations were unfulfilled. Attempts to

re-motivate him failed. His initial injury occurred more than 10 yrs ago, and was intermittently manageable.

Case Interpretation: This client endured the physical ravages of the complaint for many years and kept on working. His hope of returning to normality now only rises with reluctance. His predominant gesture in these times is assistance seeking, a tactic he takes from one person to the next, believing he is fulfilling his end of some social contract. The stance may be independent of whatever the psychologist does, and automatically gets taken over to the next person. If it fails, the individual can be provoked into hostility. He sees himself as having denied himself, working, being injured, then discarded and laughed at. At times he demands revenge, but usually abandons this stance when a new treatment or diagnostic procedure is promised. Alternately, he trivializes everything, his painful complaint, the post-accident experience, because he cannot tolerate the actual emotional impact and is unsure of the effect its display will have on the relationship with the listener. It would probably be unneccessary and unwise for the psychologist to comment on the gap between the seriousness of the issues and the tone of the emotional display.

Case 6 (a)

Summary: A man endures surgeries and pain and keeps on working. The pain grows worse, and he gradually loses hope. Occasionally he looks for a medical answer, but there is none.

Descriptive components: The client was given several different medical diagnoses, and had gone through a large number of painful medical procedures and failed surgeries. He no longer has faith in physical therapies. Despite a good initial medical experience he does not now accept medical assurance regarding the safety of physical activity. He delegates responsibility for treatment and for getting better to others. He will take pills and have surgery but will not do biofeedback or use other self-help procedures. The client does not feel well enough examined medically or cared about to let go of that avenue and prefers, instead, to accept the most disabling and threatening diagnosis among the multitude offered. The psychologist doesn't believe the client's description of the complaint and of physical limitations.

There is a lack of physical documentation of the complaint and the client is at times inconsistant. The client describes sexual problems and sees himself as severely physically damaged and asks for a full pension. He displays self-protective bracing. He does not accept the remaining pain as

tolerable. He describes family relationship problems, serious unavoidable financial commitments and current financial difficulties. The client does not acccept or understand his own reaction to extended pain or accept a psychological component in its resolution.

Case Interpretation: The client seems convinced that a cure exists, and wonders why he is denied it, which leads him to test himself against various criteria and try various tactics to get what has been denied him. He speculates whether rage, sadness, demandingness or cooperation would work. Despite these strategies the problem remains, and mutual mistrust between client and psychologist increases. Another aspect of the problem may be that the client is unwilling to abandon the notion that the pain is providing him with valuable information, which must be shared and attended to, while the therapeutic team may feel the information itself is the problem.

On the physical level, perhaps the client wants to push away, to have the badness within himself cut out. He does not want to accept being as he is. The responsibility, in his opinion, is on the treatment staff to return him to status quo. He sees the failure to do so as a betrayal of a sacred trust.

Case 6 (b)

Summary: A formerly athletic individual suffers an injury, sees the pleasures left in life as meagre, and despairs. He is offered a chance for a step by step improvement but turns away.

Descriptive components: The client attempts to retreat from the world through a pension. He feels dependent on WCB and does not believe he could be well again. He seems depressed. He specifically says he is proud of his pre-accident physical condition but is now self protective in physical demeanor. He has not learned to work through pain, will not follow excercise instructions, and re-education in eating habits, amount of physical activity, endurance training and body usage were unsuccessful, as were attempts to re-introduce him to the physical therapies. He would not accept some remaining pain as tolerable and wanted more examination despite a great deal of previous diagnostic workup. He could possibly be described as a treatment addict.

Case Interpretation: The client seems uninterested in letting the past go, uninterested in forgiveness, uninterested in participating in the present. On the one hand he complains about the residual effects of too many X-rays and

treatments, on the other, he wants more. He would rather be mentally engaged in the problem, than act to change it. He may have a sense of drowning while others are on a pleasure cruise, and the sense of danger and betrayal changes his relationship with the future in that he cannot attend to the explicit and the immediate because he is too engaged in considering the distant and multifaceted dread.

Perhaps the pain also legitimizes the distance between what the client is, and feels he ought to be. "I would be somebody, except for the pain..." etc. The pain can act to depotentiate interpersonal criticism. The client indicates this may be the case by tempering his interactions with relationship breakers to show that he is not socially dependent or engaged, and that he can freely disregard any derision, and it is pain that grants his special status. This tenuous matter of relationship building also interferes with positive engagement and the power of modeling and reward and the credibility of instruction.

Case 7

Summary: A discouraged man has a dream. He will not be happy unless he lives that dream, but he lacks the courage to act on it.

Descriptive components: The client feels dependent on the WCB, he does

not believe he could be well again and attempts to insure continuing viability in the world by pleading for a pension. He feels it is no use trying and displays poor self- confidence. When in trouble, he withdraws rather than seek help with his pain. He feels he was pushed in early life into the wrong career and sees the world as continuing to demand too much.

Case Interpretation: This may be another individual who takes pain as an indication of flaw in himself and insists on hiding with it or manufacturing a cover story that will allow him to remain in human company unexamined. He may feel the gap between where he is, and absolution to be so wide that no conceivable therapy can bridge it; yet he still communicates. The client may not want to take part in real activities because he does not want to risk having his hopes raised, knowing as he does that no way across the gulf exists; or risk becoming the fool for someone who will exploit him or confront him too forcefully with himself. His flashes of talent are an embarrassment because they focus attention on him and confront him with his failure to act.

The client may attempt to rid his life of those who feel and who know, and make it mechanical and distant to avoid pain and self-awareness. Not only does he not wish to be dependent, but probably not even close enough to

be commented on and judged. However, participation in the world is a requirement of compensation and of therapy.

D. GROUPED DESCRIPTORS

In order to encompass the separate viewpoints of the the seven psychologists, I divided the interviews into essential themes. I then condensed these as much as possible in terms of meaning. Some themes were found only among successful clients, some only among unsuccessful ones, and some in both. The themes within each group were arranged in order of frequency, (seen below), and these represent an attempt at deriving common meaning from the multiple case descriptions. After a listing of these themes an integration of their meaning as a group is made.

Themes Common to Therapeutic Successes:

Motivation and world involvement

Client sought out individual therapy, was enthusiastic, sought out information on how to get better.
Client was assertive, independent, self-affirming at discharge.
Client was an outsider with a dead end job, now going to a good job, reinclusion into the world, where therapist played a part.
Client had been in his own business.
Client wants to get on with life, away from pain and compensation.

Therapeutic relationship

Good initial therapist-client relationship.
Mutual affection at termination.
Initial distancing by therapist.
Client has faith in Psychologist and psychological intervention.
Client was initially not responsive to therapeutic initiatives.

Work Issues

Vocational clarification occurred, lighter, more plausible job was located.
The client liked pre-accident work.
Lack of job alternatives, then adjustment to and return to pre-accident job occurred.
Physician told him he would not work again, which motivated action.

Client became depressed again after success because of no work, positive mood returned along with vocational opportunity.

Social investment and relationships

Client is part of a close-knit community.
Initially client seems independent, assertive, sceptical, pseudo socialized, or paranoid. Client sees self as a misfit. Eventually a good therapeutic relationship and more faith in success in the world.
Spouse got a job, relieved financial strain.
Good family relationships.
Good relationships with other centre therapists.
Client has experience of social transgression and wants to confess despite previous therapeutic rejection and rejection by other community members, and he gets this.
Despite having tried all, client still wanted more medical treatment.
Family was involved in the treatment programme at home (diet).
Client lost possessions, suffered financial strain.
Client fed up with assurance and failed medical treatments.
With little or no improvement under standard medical treatment, client was blamed for the problem, and resented it.
At termination client ceases display of disability.

Body relationship

Client worked through the pain.
Client accepted it is all right to have some remaining pain.
At discharge client is working up to the limit, up to point of pain.
Physically self protective at start of treatment.
Activity increases pain.
Client worked for some months after accident until this no longer possible.
Client wanted out of the pain experience and was willing to accept psychological treatment, despite lack of confidence in it.
Client has difficulty accepting limitations and disability.
In good physical condition at start of psychological treatment.

Compensation issues

Client takes the system for something it's not,something more than an insurance company. Seeks symbolic rescue.
Limited money from compensation - too low in clients opinion.
Client had trouble justifying relationship between accident and disability due to time delay.
Client wanted education financed by Board.

Client was in Rehabilitation Centre on a number of previous occasions.
No system problems.

Self relationship
At discharge client was willing to meet future without guarantees. Different in presentation, cheerful, smiling, communicative, mobile.
Client fears own violent impulses, keen to maintain control, suppressed, keen to do well in the world, to be accepted.
Client shows generalized fear.
Resistant to accepting a psychological component to problem.
Client in therapy is surprised by insight into own dynamics.
Low back pain a long term problem, client's whole life was derailed.
Client had many previous experiences of winning and losing in life.

Process in therapy
Successful education re. mechanics of body function included in therapy, Biofeedback included, as well as return to physically active therapies.
Successful re-education, in eating habits, physical activity and endurance and weight loss occurred.
Successful charting and documenting state of being and progress.
Change was like a religious conversion. A wholescale reframing to more positive attitude.
In therapy client reaches change in social interacting style.
Client is able to relax at termination.
More disclosing at discharge.
Psychologist helped client over physical setback.
Therapist was reluctant to witness self-exploration because it was too frightening and violent, but did.
Client continued weight loss after end of therapy.
From a dependent 'let someone else fix it' to independent self help.
Client was in charge of the therapeutic relationship and wanted to learn specific skills or techniques.
Client felt he had to prove his honour. Therapist said:"let it go".
Client confronted significant other and won.

Medical Issues
Client takes medical assurance, accepts that activity won't cause damage.
Client recovers positive mood following improvement due to chiropractic care.

Discussion of descriptors common to Successful Cases

Successful individuals can, with the intervention of the psychologist, become motivated by their difficult predicament. They react more positively to the helping hand, and they accept reinclusion, and/or are willing to emulate a model. They have more patience with their body and they are more willing to learn how to use it differently. Principally, they are willing to <u>believe</u> for a while longer.

Since all these people were in desperate situations before success occurred, barely hanging on, self-exploration and change of basic assumptions must have seemed a risky endeavour. One conclusion may be that the client had been forced apart from experience, and stood there commenting on it, and in the course of treatment re-entered, got back into life, community, body and fate. The client did the excercises despite the pain, or carefully and responsibly up to the point of pain (depending on physical realities, I expect), and took charge of social interactions and vocational future. The back condition ceased to be a label of differentness and became a private badge of success and eventually a part of ordinary living. While the client initially tried to manipulate others by keeping relationship issues in foreground, later became likely to move to self-responsibility and task-orientation. The client does not need to flood out fear of the future and complexity with emotion, or

keep it out with physical tension and thus perpetuate the burnout cycle. The client may not need to hide behind the sick role, nor look within for reasons for being visited by this punishment but, like Job, accepts that it has as little to do with oneself as with the divine will, that it just happens.

The successes, then, included mainly those with a potential for a willing, enthusiastic approach to treatment.

Themes Common to Therapeutic Non-successes:

(These themes occurred in one or more non-successful cases and none of the successful cases.)

Motivation and world involvement
The client is depressed: "No use trying"
Client attempts to retreat from the world via pension, feels dependent on WCB, does not believe in being well again,
Client prefers to accept the most disabling and threatening diagnosis

Therapeutic Relationship
The client is manipulating.
Therapist doesn't believe client regarding complaint and physical limits.
Lack of documentation regarding strucutal abnormality and inconsistent behaviour.
Client did not want therapist to try and cause change, just to attend.
Client is going through procedures only to please therapist.
Client puts physicians on pedestal.
High expectations are unfulfilled.
Client sees psychology as a place sheltered from pressure to excercise and job hunt.
Client trying to prove self to persons in authority, and losing.

Work issues
Client feels pushed in early life into wrong career.

Social investment and relationships
The client reports sexual problems and masculine (active) role erosion to which he reacts with physical self protection.
Divorced
Client feels society owes him.
Martyr.
Client withdraws rather than seek help with pain

Body relationship
Client has not learned to work through pain, would not follow excercise instructions, unsuccessful re-education in eating habits, physical activity, and physical endurance.
Client will not accept some remaining pain.
Client specifically is proud of pre-accident physical condition.
Bizarre somatic convictions.
Client will not relax even in relaxation training.
Coped for time with pain but now sees self as disabled.
Initial injury more than 10 yrs ago, intermittently manageable.

Compensation issues
Client sees self as severely physically damaged & asks for full pension.
Client has many years of involvement with various compensation boards.
Saw resolution in enough money to start business.
Client has a lawyer represent him with the Board.
Money from compensation is threatened by improvement,the therapist notes.

Self relationship
Delegates responsibility for treatment & getting better to others,
will take pill or have surgery but not biofeedback or other self-help.
Does not feel well enough examined medically or cared about.
Wants more examinations.
Treatment addict.
Present low back pain plus leg pain, poor sleep, multiple drugs in use.
Substance addiction and blaming others for it rather than trying to change.
Grandiose and unrealistic plans & no follow-up in action.
Low general self confidence.
Client feels he could have been killed in accident (lost faith in world as an even moderately safe place).

Process in therapy
Client has been previously with psychology and/or spent a long time there

receiving therapies of one kind or another.
Does not accept medical assurance regarding safety of being active.
Mixed medical diagnoses, too many medications and treatment procedures and failed surgeries - no faith.
Client is seductive, manipulative, wanted to touch therapist, exhibitionistic.
Therapist switches to authoritative approach after failure at less directive approach.
Client has no religious faith.
Client has an ugly, scary, socially unacceptable appearance.
Client describes a good initial medical experience.

Discussion of descriptions common to non-successful Cases

The individuals described here seem separated from the community and from their body, and appear not to believe that they have the potency to cause re-inclusion and improvement. Some refuse to believe, some believe, but will not let go of the helping organization. For some, injury is a more honourable route off the unbearable treadmill than failure. It is also more financially rewarding. Some clients simply do not want to hear about getting back onto the Hay Wagon. While some therapists considered absence of religious faith an additional hurdle in that the client then has to take on the whole universe, others ignored the topic, some pointedly.

Themes Common to both Therapeutic Successes and Therapeutic Non-Successes:

Motivation and world involvement
Initially the client sees the world as demanding too much.
High pre-accident income.
Low education, training & job qualifications.
Poor English.
Client an immigrant.

Family relationship problems exist.
High financial commitments & financial problems.
Client does not acccept or understand own bodily reaction to extended pain.

Body relationship
Poor anatomical understanding.
Client claimed to be in good pre-accident physical condition.

Compensation issues
Fighting with/ Hostility to system.

Process in therapy
Instructional approach used initially.
Structured pain control program, group, therapeutic excercises, relaxation training group, plus individual counseling employed.
Client liked the relationship in therapy and the ventilation opportunity.
Therapist notes that the client was physically attractive.
Client reports recovery from a previous low back surgery or episode.

Discussion of Descriptors present in Both Successes and Non-Successes

All of the above descriptors were duplicated among therapeutic successes and therapeutic non-successes. Individuals in both of these groups were exposed to financial, situational, linguistic and bodily stressors and were described in similar terms as far as therapeutic relationships and personal attributes were concerned. There are, of course, structural differences between sufferers which push the individual toward either success or non-successes. For example, the

worker who has for years insisted that the pain is 'real', that the fusion has re-broken, may find confirmation of this through a novel diagnostic procedure like a CAT scan. He may then undergo new surgical procedures and do well. Still, more often, it is a question of either accepting or setting about to change a particular problem - or refusing to do so. Those who refuse to either accept or change are more likely found in the non-successful group.

Since all of these dual factors existed in both the non-successes and the successes, we can see that loss and threat and overwhelming odds can either motivate or immobilize. This is the ideal entry point for the psychologist.

E. Reactions of the Therapists to the Interview Process

The psychologists commented on the fact that their particiption in the study lead to a re-examination of the techniques and hypotheses employed in daily practice and sparked renewed interest in the types of cases described by others in the department. The psychologists typically asked what type of client did others find memorable, interesting, and specifically successful and unsuccessful, and what were their opinions about the utility and efficacy of various psychological services. This curiosity could not help but lead to

curiosity about the interviewees own techniques and lead to questions about their possible overuse of specific strategies.

Since the Psychology Department is often the last stop on the client's journey through compensation-sponsored treatments, the telling and re-telling of the therapeutic encounter often lead the interviewee to reassess the finality of conclusions. Some specifically commented on the loss brought on by designating a relationship an irreversible treatment failure.

In cases of treatment non-success the psychologists were open to admission of personal loss of faith or efficacy. They expressed genuine regret and firm conviction that in these cases there was nothing further that could be offered, either because the suffering was so much reality based and prolonged, or because, the apparent short term rewards of compensation financing and social role were just too strong for a client.

Almost inevitably, the clients referred to psychological treatment have had negative treatment experiences and negative compensation experiences because of the duration of the problem and the lack of structural documentation. In cases of success it seemed to several of the psychologists that it was the personal engagement between them and the clients, as human beings, and a sense of mutual honour, which

allowed them to transcend the gulf of suspicion which arises in the compensation siutuation, where the therapist also has the power to alter the financial fortunes of the client, and the client has the power adversely to influence the therapists civil service and professional career.

The psychologists repeatedly complained that the culture as a whole misrepresents the human condition in suggesting that most bodily problems are fixable, when in more likelihood, most are not. In consequence, the clients enter psychological services often with convictions that wrongful action by a surgeon has occurred and is being denied, or that good treatment is being witheld, and that these are the reasons why the pain persists. Sometimes the psychologists were able to convey the need to abandon false hopes of medical resolution, sometimes they were not. That variable is probably more dependent on the client's stance than the therapist's personal effectiveness. The lures of continuing to look for medical solutions and await more specialists' appointments are much the same as the lures which entangled many of the treatment non-successes, namely continuing financial support from compensation and continued role definition while the search goes on. Perhaps for that reason the ranks of treatment

non-successes contain many who persist in putting their hopes in the next orthopedic surgeon's word.

F. Relationships Between Client and Treatment Approach: What Does Work?

In reviewing treatment procedures with the psychologists, the following became evident: the brand, or type of approach was less relevant to success than the establishment of the following:

1) A relationship in which the client seriously considered the opinions of the therapist. (This respect was mutual in all successful cases but one, in which the therapist initially avoided the client, whose private stubborness nevertheless kept him at task. This stubborness then led to respect of this interpersonally difficult client by the psychologist).

2) A change in the view of the condition by the client (again there were exceptions, in which the client's physical condition remained the same, but social relationship success and self confidence increased).

3) A depotentiation of the world. In the successful cases the world changed back to modest and influencable dimensions, and away from the overwhelming scoffing entity it had become during disability.

Successful clients were able to approach previous employment and worldly tasks without overwhelming anxiety and the consequent low back pain.

4) A changed view of the compensation system, from that of an unwilling mammary gland to an insurance agency with bureaucratic quirks appropriate to its role.

5) An association between the psychologist and the client which depotentiated the client's apparent dangerousness in the eyes of the remainder of the organization and to his social group occurred, and thus allowed for more positive feedback to the client. When such potentially dangerous clients acted out, the psychologists intervened to assure the world and thus maintained the client's place in it.

6) Reframing occurred, sometimes in a religious fashion, of horrific experiences into worthwile growth events. Analogously, some clients began to perceive even their marginal existence as a gift of grace, and decided that life with its present limits is preferrable to non-existence.

7) A somatic change took place, including a knowledge based re-utilization of the back muscles as means of locomotion, rather than the use of these muscles as tools with which to bludgeon pain.

8) One further conclusion offered by the psychologists was that positive change depended primarily on the stance and condition of the client, and the consequent possibility (or the lack of) therapeutic engagement, so that no general conclusions about the superiority of one approach over another can be made.

What Does Not Work?

In these cases the whole necessary sequence of therapeutic events failed to occur, starting with the lack of a productive working relationship, and including the failure to utilize the therapist's knowledge base to look for bodily and social behaviour alternatives. In these cases the client's belief system appeared more fixed, perhaps more cynical, perhaps more preoccupied with past or with perceived betrayals. (Many of the clients in both groups had been repeatedly cut off from and reinstated on compensation because of the lack of clear cut documentation of physical pathology. It may be that the failed cases responded to this differently, and took it as an unchangeable relationship marker). These clients, who could not be therapeutically engaged, could not also be made to take responsibility for the course of the complaint, for their future, or for eventual independent existence.

Perhaps the major common point among the described

non-successful cases was that these clients would, for right or wrong reasons, simply no longer BELIEVE.

CHAPTER 5

DISCUSSION

A. The Findings

We had set out to shed light on what compensation board psychologists can tell us about success and non-success in treating individuals with chronic low back pain. Looking at the information in a variety of ways and re-integrating the results we saw in Chapter 4 that:

a) they report characteristics and themes common to successful client - psychologist interactions

b) they report characteristics and themes common to non-successful client - psychologist interactions

c) they report characteristics and themes common to both

d) a practical methodology exists for capturing and distilling the material

e) there is a need for much more real-life research in this area.

B. The Described Themes

Successes

It seems, in the comparison of successes and non-successes, that even among these very desperate people 'them that has, gets'. The successful

clients were more enthusiastic, trusting, and interested in getting better. They were capable of maintaining good relationships with psychologists and with their own families, they liked their jobs and wanted independence from compensation. They were willing to learn new bodily, social, and self-management skills, and were willing to either work through the pain, or up to the point of pain (most likely as dictated by physiological realities). Some clients initially had difficulties accepting their disability. Some tried for many years to cope on the job, and others were disbelieved and blamed for the problem. Despite these experiences, the successful clients learned to wean themselves from the notion of a standard medical cure and still remained open to disciplined self-observation such as charting, to the maximization of small gains and a return to work and acceptance of the future without guarantees. Sometimes change occurred through a reframing of previous experience, sometimes through change in social interaction and consequent benefits, sometimes through somatic retraining, sometimes through redirecting the client from rage and bravado.

Some of the differences and contradictions among clients in this group can perhaps be accomodated by postulating that there are essentially three types of individuals who succeed:

a) the antisocial or asocial individual who needs to be allowed to re-join

in or taught how to function better,

b) the client, dependent on medicine and demanding the impossible from the doctor and society, who has to be taught to do with less, or do for himself, and

c) the client with good social support and personal resources who needs to be taught somatic and psychological skills for survival with the complaint.

In all this let us not forget that all of these individuals were failing before psychological intervention took place. The above are attributes developed by, seen during, or arising coincidentally with psychotherapy, but attributes which had not arisen previous to psychotherapeutic contact despite the client's participation in many other treatments.

Conclusion

We can propose that these clients had been forced to part from their automatized existence and stood there observing themselves and commenting on their experiences. In the course of treatment these clients re-entered, got back into life, into community, body and fate, and directed their attention back out onto the world and away from isolation and derogatory self-assessments. The contribution of the psychologists lay in facilitating this process, and the interviews afford an insight into the difficulties often inherent.

Non-successes

According to the thematic groupings, some of these clients were seen by the psychologists as personally unattractive people who previously had been given a variety of diagnoses and treatments, including psychological or psychiatric diagnosis and assistance. They lacked a willingness to believe or grant credence to the present treatment attempt and though they could be induced to daydream success, they lacked the self-confidence to carry out their plans. They also lacked faith in their own power to initiate self-help. Some had managed to pass from day to day for years with an increasingly incapacitating problem and had no resources left to carry on, and now looked for an honourable exit via pension.

The non-successful clients typically failed to follow activity instructions and refused to challenge the pain. They would not relax or try to control excessive eating and other somatically and psychologically undesirable habits. Some were addicted to drugs, most had sexual and role-erosion problems to which they responded with anger or dependency but not with active conation. Some withdrew from interaction altogether. These clients, having lost major battles, sometimes saw the Psychology Department as a place sheltered from the pressures imposed by the demands of the rest of the organization. They felt society and compensation owed them more than it

was willing to give, and they more often used adversarial means such as lawyers, to try and get what they thought was their due.

The psychologists described these non-successful clients as manipulative, inconsistent in behaviour, prefering to believe the most disabling diagnosis, and as addicted to medical assistance. Some of these failing clients used illegitimate and destructive interactive strategies, and some were seen as not improving because of the immediate reward of compensation payment and social attention guaranteed by the presence of the complaint. Again, there appeared to be two types of clients:

a) those who continued to plead, demand and explain,

b) those who insisted on his/her due but asked for no interpersonal recognition or assistance.

There was one client, (who probably typifies the disappeared ones, those injured workers who cannot be located,) who withdrew when in difficulty, and for whom the psychologist had to actively search.

The psychologists sometimes had a problem dealing with specific failures, and as much as I tried, I could not in every case keep them on specific issues, and away from generalizations during the initial interview. Nevertheless, as Merleau Ponty reminds us, fact has primacy, and what they said represents a close approximation of what could be said under the

circumstances by individuals likely to be found in those circumstances. The interviewees subsequently had ample opportunity to review and add to the text and the interpretations, and I used the followup sessions to fill in omited materials.

Conclusions

For me, this is the most difficult section to summarize because it crystalizes the differences between the assumptive spheres of our profession and the living realities of the world. Ideally, there should be no non-successes, and it is possible that there are alternate therapies or more masterful psychologists who could bring these individuals around. It is also possible that there are sequences of somatic and psychological events from which there is no recovery, or times when the extended hand, no matter how warm, will not be grasped.

Failing low back pain clients constitute the largest category of compensation claimants, and are the most expensive to treat and maintain. I know that compensation boards, and compensation psychologists, will continue to welcome any worthwhile assistance with this issue that can be offered.

The Implications of Themes Common to Described Successes and Non-successes

Most interesting of all seem to be the dual factors, those which were identified in both the cases of success and of failure.

There were clients in both the success and non-success groups who were typified by:

-high pre-accident income

-heavy financial commitments

-current financial troubles

-low education

-low training and job qualifications

-poor English

-problems on the home front

-and battles with the compensation system.

Clients in both groups reported themselves fit and potent before the accident but now saw the world as demanding and overwhelming. People of both types reported recovering well from a previous surgery or incapacitating back pain episode, and reported enjoying the ventilation aspect of therapy.

Conclusions

These findings remind us that it is not pinpoint facts, but the reality

behind them and the complexity of their sequencing and interaction that determines outcome.

C. Implications

1) The process of data collection used in this research effort rejuvenated an interest in the fading practice of individual case presentations in the Department. It also generated curiosity in the psychologists about the types of clients described by others, about the experiences of others in the Department, and about their strategies in coping with personal impact of the job.

2) Recent months have seen an intense questioning of the effectiveness of the various treatment approaches, not only for cost cutting, but from genuine curiosity as to the relative long term efficacy of, for example, group relaxation and stress management training versus individual counseling and group versus individual biofeedback treatment. As a result, all clients are now routinely given assessment questionnaires at the conclusion of group therapies, and at the end of their stay at the Centre, and a government-funded project aimed at long term follow-up has been initiated. Concommitantly, a research committee has been struck at the Centre which is now in the process of reviewing several low back pain treatment evaluation proposals.

3) Several of the interviewees felt as they repeatedly re-examined and discussed details and implications of their successful and unsuccessful cases that they perhaps overused a once-successful strategy with an obviously floundering client.

4) A benefit to the interviewees of the crossfertilization involved in this research lies in the describing and the listening, and leads to the realization of how different other psychologists' clients seem from one's own. This difference points to one's own role in eliciting certain types of client behaviours, and to punctuating and naming certain sequences of interaction as key features. For example, hearing a member of a particularly type-cast ethnic or diagnostic group described in unexpected and sympathetic terms can have a liberating effect.

5) A further benefit, again attributable to the telling and re-telling is the realization by those involved that it is important to take the time to do the right thing. The non-successful client will still be around and all the administrative storms and furies will do nothing to change it. The telling and re-telling shows that there is no profit in rushing the client through the stages and attempting to speed up the outpouring of bitterness in order to reach the other shore.

6) Though not a result of this undertaking, it so happens that a definite

administrative change in this direction has taken place, activated by analogous insights reached at higher levels in the organization. One of the interviewees happens to be the person put in charge of that new treatment philosophy for the whole organization, and will, I believe, take these insights with him.

A Counterpoint

There is, of course, the reader who will bring forth the following point of objection: how can anyone pretend to make sense of the dreadful caterwauling of the human race, which is the inevitable consequence of being conscious, mortal, and embodied? Pawel (1984 p.57) attributes this starting point to Franz Kafka. I sympathize with such a reader and freely concede that there are many unanswerables in this complex situation, but defend the legitimacy of sense-making efforts.

D. Directions for future research

1) Some of the mauled people described in the interviews succeeded, some failed. Perhaps the difference was attributable to inherent toughness, perhaps to the effects of treatment, perhaps to a particular chance interaction between anatomical limitations and the psychologists' belief system. (Some psychologists believe in working <u>through</u> pain, some up to it. While one approach may be more suited to individuals with shortened

ligaments, the other to those with joint malfuncions, and so on). The problem is not a lack of models which could guide the psychologist to adopt recommendations and demands to the physical situation. There is, in fact, a mad preponderance of models, to the point where, literally, one year a great enthusiasm exists in the physical disciplines for extension, next year for flexion, one year for "no pain no gain," next year for careful stretching. One month the recommendation is for Earth shoes, next for bare feet, and the one after for soft insoles with built up heels. In addition, the individual preferences for soft-hearted vs. hard nosed treatments adopted by the referring physician set the initial tone of the relationship.

The problem is not lack of effort by the psychologists to become educated and to do the right thing. The problem is the sheer volume of models and treatment hypotheses in the physical domain, and the impossibility for the psychologist to find anyone who can say, with a meaningful degree of certainty, whether a particular client does or does not have a physical complication imposing its own rhythms and limitations on treatment events.

2) There is also the matter of a match or mismatch between the stage of adaptation of the client, and the stage of the psychologist's tenure at the Board, and consequent willingness to tolerate aggression, demandingness, and the like from the client. As noted, there are pronounced differences not

only in values but also in communicative style between the worker's strata and those of the psychologists. It is often difficult for the welder just off the pipeline to interact with the gentle civilian world, and spend an evening at a bar or a day at the insurance company without getting into a physical fight.

While the beginning psychologist may be more willing to take the battering and forgive confrontation spewing from a worker who still considers himself to be out in the work world, the more experienced psychologist may put an immediate stop to it. The more experienced psychologist may, however, also be more able to dismiss this aggression as unimportant to diagnosis considerations. The matter of which approach is more productive is, like so many other issues, only a tiny part of a larger whole, and difficult to research.

3) A further problem in conveying the meaning of another's experience is that, as in a boxing match, information in compensation is not always meant to communicate, but sometimes to disinform, to trap the opponent into disadvantageous action. In compensation, the client often sees the Board as such an adversary, yet in psychology he is expected to tell the whole story. Straight forward communication was more frequent in the past because Psychology was not consulted in questions of payment. Now that

psychological impairment is compensable and our opinion can mean more money in the bank, psychologists can no longer assume they are getting the unadulterated truth. This change of policy can have startling consequences in situations such as the compensability of (and consequent frequency of admission of) sexual impotence. Still, the experienced psychologist may resist responding to the client's attempt to control information flow, and assume, despite attempts to disinform, that the client's longterm motive is to improve.

The combination of pseudo-information and sincere desire to improve does occur quite often, particularly in situations where the client has previously been discharged on the basis of a negative medical report only subsequently to obtain other physical documentation of continuing disability. They now, understandably, want to squeeze while the squeezing is good, so as to have the time to put themselves back onto their feet. Here the beginning psychologist may overreact to an instance of verbal excess, while the more experienced psychologist keeps an eye on the long-term goals.

4) Another problem is that: "A person cannot truly play or celebrate if ... forced to participate" (Straus 1967 p.143). Similarly, the person pushed toward inattentiveness to pain may become the over-vigilant guardian of all personal inadequacies. One who is babied and attended to can become

preoccupied, and once such over-focusing has come into place, it is difficult to displace. The question of how to deal with chronic pain without unduly focusing on it still remains a mystery.

5) A ritual of purification may be needed to separate the dread from the pain. This might occur through medical assurance as to the stability of the complaint, but with failed clients typically does not. If the physician says: "don't worry about it, it is benign'", but can't fix it, he is impotent, and this undermines his credibility regarding the original assurance. The psychologist is usually not seen as a participant in the struggle with the physical problem, and experience shows that his/her offered assurance in this arena has limited power (though explanations accompanied by books and articles can be persuasive).

6) Confession is a declaration of the end of mistrust and separateness, an end of the need to out-think and out-manouver. Psychological testing can either make that happen, or leave the client feeling robbed, raped, and known without consent. At present, psychological testing in the clinical situation tends to be more often the latter than a constructive re-joining confessional. More effort may be required to make testing into a constructive pro-client tool.

7) We need to find means by which the client can be innoculated against

dread of recurrence (which is sure to come sooner or later with chronic low back pain as a result of slips, falls and false moves). Typically, instead of innoculation against recurrence, the worker has a well established mechanism for dismissing improvement.

8) We need to find better ways to integrate psychological findings into the world, and for that a knowledge of the intricacies involved is essential. While employers are not allowed to discriminate on the basis of sex, religion, age, or criminal record, they can and do severely discriminate on the basis of health, compensation record, and particularly past incidence of low back injury. By holding the employer responsible, and finacially liable for an ever increasing range of maladies in the workforce, regulators have forced employers to be reluctant to hire anyone except the wholy untouched, or the documentedly handicapped, for fear of dire financial consequence. On the other hand, of course, there do have to be stringent means by which employers are held responsible for the quality of safety and work conditions, particularly in non-unionized sites.

Limitations of the present Research Approach

A major shortcoming is, obviously, that I am part of the situation, that I have an existing relationship with the interviewees, and must, in the process of producing this thesis maintain my relationship with the organization, with

my family, and with the readers. But while it may in a sense be better were I NOT part of the situation, I would then more likely miss the important and major dimensions which exist in the world I address. If I didn't have long-term personal exposure to the situation, I would be more likely to approach the problem from an inappropriate horizon. This missing of major dimensions, and consequent risk of irrelevance, is a problem when outsiders excercise their research talents on a living clinical situation they do not understand (Faltin and Dickinson, 1984; Frankel, 1984).

Under more leisurely circumstances, I would love simply to outline my vision of the horizon, then gather small insights and individual contributions of esoterica, proceeding in a gentle circular motion, perhaps taking years to portray the elephant we are trying to describe. My own bits of contribution might resemble the observation that a good diagnostic sign to determine if a particular client will be a success or non-success in therapy is the chair in my office. It has a loose bolt under the left armrest. The client who reaches underneath and tries to tighten the bolt will likely do well. One who does not notice the loose bolt in the intensity of complaint and simply carries on, will probably take longer. The small effort to fix the arm rest apparently implies ability to perceive, involvement in the world, some sense of power, and the courage to act. These were the characteristics that described the successful

clients.

CHAPTER 6

PERSONAL IMPACT OF THE THESIS

This research dealt with descriptions of therapeutic experiences and insights told by my fellow psychologists. In the process of chasing down a complete description I was forced to become more patient and open minded, and I came to appreciate in much greater depth the differences of our viewpoints. With appreciation came surprise at diversity, and renewed appreciation for the department members as persons. They carry on in silence in the bureaucratic setting where they work, by and large they are cut off from other disciplines in the Centre by differences in mandate and assumptions, and cut off from each other by the inevitable strains and competitions in the department. They grow fatigued of repeated truncated mutual assistance and sometimes they despair because of the inescapably solitary nature of their burdens. Still, they endure without cynicism.

In researching the ground I also came into contact with people and material which made me appreciate the complexity of the compensation process as a whole, and the difficulties experienced by those handling the technical (rather than the human) side of compensation. I have also developed an appreciation for the patience and the unspoken support granted me in my place of employment during the long struggle to finish this thesis; a time

when I was not always entirely pleasant and bushytailed.

In the past six years of employment at the Rehabilitation Centre I saw more pain than I thought existed in the whole world. As a result of the introduction to phenomenology and hermeneutics which I received in the course of this thesis I experienced some return of faith in psychology's ability to deal with such real situations meaningfully. The resulting figure and ground described in this thesis can, I believe, provide us with a basic sense of prevailing reality, and with a platform for launching other excursions into this deserving and poorly charted region.

What, though, is the synthesis of the whole effort? What does it all mean? Perhaps that comes to us best not from psychology, or medicine, but from sports, where Sheehan (1978 p.23) writes: "The offense ... is play. The defense is work. When I am on the offense, I create my own world. I act out the drama I have written. I sing the song I have composed. Offense is unrehearsed, exhuberant, free wheeling. Offense is an excitement which provides its own incitement. ... Its own driving force. It generates its own energy. It cannot be forced. It is spontaneous, joyous unification of the body and the mind. ... Defense is none of this. Defense is dull, boring, commonplace. It is the unimaginative, plodding attention to duty. It is grit and determination and perseverence."

I have no doubt that the thesis changed me; on the whole, for better. For one thing, it taught me about staying on the offensive. For another, it taught me discipline. The day-after-day sequence of work life, family life, reading, and thesis writing, which didn't allow much free time for emotions to thrash as they wished finally had an effect. I would not have called that impact a positive one before it occurred, but I am now starting to realize that discipline is, after all, an essential aspect of social existence. The thesis helped me to subsume a rebelious and mistrustful soul to the required rituals of the world. It was probably time to grow up.

The thesis work, which lasted in various forms for seven years was also a process of ideological change. I started from the position pinned down by Lasch (1984) wherein as a member of the 'helping professions' I was forever siding with the idea of more government intervention in the ways of the world, only to agitate against the authority of the institutions thus created. I believe the thesis taught me the irrelevance of such posturing. It also taught me that suffering is unavoidable (Moulyn, 1982), that time is the only true purgatory (Samuel Butler in Flesch, 1957), and that in the end, one experiences essentially nothing but oneself (Nietzsche in Orange, 1910).

I think I was principally changed by the constant confrontation with pain during the day, and the gentlemanly assumption that unpleasant things must

not be spoken of or accepted, or at least deeply felt, to which I had to return in thesis writing at night. So on the one hand there is the living realization that " ...cost effectiveness is achieved when one patient in 20 returns to work" (Spengler, 1983), - on the other is the convenient pretense that the physically damaged are really no different, that NOTHING FUNDAMENTAL HAPPENED.

On the one hand I was squeezed by my trust in Camus (in Hanna 1970 p.190-191) who tells us that future-oriented people are sick and incapable of living in the present, - on the other by an effort that interfered in daily life, in work, in holidays and in sleep and never seemed to end.

On the one hand there was the realization that parents, school, and society conspire to make us feel weak and dependent enough to be obedient, on the other that a colleague in his obedient job as technical writer gets paid more per word than Hemingway did at his peak.

On the one hand there is Kafka (in Pawel, 1984) and Kierkegaard (in Flesch, 1957 p.194) who tell us respectively: "How modest these people are. Instead of storming the institute (the Austro-Hungarian equivalent of the WCB where Kafka worked) and smashing it to bits, they come and they plead," and " Nothing, nothing, nothing, no error, no crime is so absolutely repugnant to God as everything which is official; and why? Because the official is

impersonal and therefore the deepest insult which can be offered to a person...." - and on the other hand there is my clear awareness that financial generosity without vocational assistance can be a brutal trap for the injured person.

So, in a sense, I started the project with a notion that external interpersonal reality could be described, challenged and improved. Now I view the problem encountered in the gulf between what ought to be and what is as a function of the distance between external and private reality, and I am no longer sure that action and good intention in the world the only measure of worth. Now, rather than rush in there with assumptions blazing, I am more prone to side with Paul Tillich's image that we float in a sea of pre-meaning in which dread accompanies the realization of our weakness, our temporality, of death, incapacity, pain, guilt, and of the utter uselessness of our human companions.

It is perhaps as a result of this shift to private meaning that I have at times appeared cynical about the virtues of the formal aspects of our discipline. I have never been cynical about our daily function as available witnesses to, and companions for our clients.

Given my present viewpoint, staying on the offensive with the outside world may seem a peculiar claim. To me, though, it is the natural outcome of

a realization that I am even less qualified for the inner journey, which was after all much more sensitively travelled and described by Proust, Conrad, Kafka, and so very many others. I am in any case unready for it, and my familial obligation to make a living place me firmly into an active role in the outside world. Staying on the offensive, then, consists of a determination to do a decent job of what is at hand. I share this resolve with my fellow compensation psychologists as well as with the successful clients, with whom I also share social class origins. Like those working class clients, I wish to believe that the success of this venture was due to my own solo effort, and that I am without financial or personal obligation to those in power over me. Like those clients, I suspect that I am more indebted than I quite wish to acknowledge.

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APPENDIX

The following is a listing of all descriptors derived from the original Psychologist Interviews. The list of descriptors belonging to each case was subsequently expanded, if necessary, during the repeated re-discussions of the case.

In the following list the number (1,2,3 etc.) refers to the psychologist who was the source of the material, while the subscript "s" refers to a successful case and the subscript "f" to a non-successful case. Thus the descriptors marked 1s refer to, and constitute, the initial summary material for the successful client described by psychologist one in Chapter 4.

For more information about other steps involved in this reconstitutive ethnography the reader is referred to chapters 3 and 4.

Client was motivated to improve, keen to learn and has faith in Psychologist and psychological intervention 5s
Good initial therapist-client relationship 5s 1s
Client liked his/her pre-accident work 5s
Client has lighter work to go to when therapy ends 5s
Client sought out individual therapy 2s
Client is involved but beneath that is a loner and sees self as social misfit 2s
Client has initial difficulties accepting limitations and disability 2s
Client is enthusiastic, seeks out information on how to get better 2s
Succesful at weight loss 2s 4s
Client fears own violent impulses, keen to keep self in control, suppressed. 2s

Affection from therapist at termination	3s 1s
Affection from client at termination	3s 1s
Hostility to system	7s 1s
Fear in general	3s
Fighting with the system	3f
Client takes system for something it's not, an insurance company	3s 5s
Initial distancing by therapist	7s
Poor anatomical understanding of own body by client	3s 3f
Poor English skills	3s 3f 4f
Plans to travel far away for more medical evaluation and treatment	7s
Resistant to accepting a psychological component to problem	7s
Instructional approach used initially	7s 7f
Biofeedback used	7s 1s
Client was impressed and surprised at own progress	7s
Client in therapy surprised by insight into own dynamics	7s
In therapy client reaches change in social interacting style	7s 1s
Client had an attitude of :"No use trying"	7f 4f
Client reported deterioration in own caretaking capacity	7s 3s
Initially client sees world as demanding too much	7f
Client enrolled in group as well as individual therapy	3f
Successful education about body functions and physical structure during therapy	3s 1s
Unsuccessful education about body functions and physical structure during therapy	3f 6f2
Successful habit re-education (eating, physical activities endurance)	3s 2s
Unsuccessful habit re-education (eating, physical activities endurance)	3f 6f2
Re-introduction of client to physical therapies at Rehabilitation Centre was a success	3s
Re-introduction of client to physical therapies at Rehabilitation Centre was unsuccessful	3f
Charting: Documenting state of being and progress to self	3s 7s
Client learned to work through pain	3s 4s2
Client had not learned to work through pain	3f

Client takes medical assurance, accepts that activity will not cause damage	3s
Client does not accept medical assurance, believes still that physical activity cause damage	3f 6f
Adjustment to and return to pre-accident job	3s
Client accepts it's all right to have some remaining pain	3s 7s 1s
Client does not accept some remaining pain as all right	3f 6f 6f2
Withdraws rather than seek help with pain	7f
Able to relax at termination	7s
At termination ceases display of disability	7s
At discharge the client has some pride in self	7s
At discharge the client is working up to the limit, up to point of pain	7s
Client feels pushed in early life into wrong life career	7f
Low general self confidence	7f
The client is initially independent assertive, skeptical and pseudo socialized.	7s 1s
Assertive, independent, self-affirming at discharge	7s 1s
Good initial medical experience	6f
Bizarre somatic convictions	3f
Therapist doesn't believe client about the magnitude of the complaint and extent of physical limits	3f 6f 1f
Client sees self as severely physically damaged and asks for a full pension	3f 6f
Client feels he could have been killed in the accident	3f
Client does not allow self to relax even in relaxation training	3f
Client reports he/she recovered well from a previous low back surgery or episode	6f 5s
At termination not depressed	3s
Initially not responsive to therapist initiatives	3s
Client does not acccept or understand own reaction to extended pain (the physical consequences of stress)	3s 6f
High pre-accident income	3s 4f
Family relationship problems	3s 6f 2f 4s2
High financial commitments and financial problems	3s 6f
In clients opinion his/her compensation rate is inadeqate	3s
Lack of apparent job alternatives	3s

In good physical condition at start of treatment	3s
In poor physical condition at start (specifically mentioned by the psychologist as an extreme case. Most clients are in poor condition in any case)	6f2
Delegation of responsibility for treatment and getting better to others	3f 6f
Client attempts retreat from world via pension	3f 6f2
Claimed good pre-accident physical condition	3f 6f2 1s
Specifically says he/she is proud of pre-accident physical condition	3f 6f2
At discharge not insisting on complete cure	7s
At discharge is willing to meet future without guarantees	7s 1s
Depressed at discharge	7f
More disclosing at discharge	7s
Unable to commit to vocational direction because he/she has low self confidence	7f
No religious faith	7f
Coped for time with pain but now sees self as disabled	6f
Sexual problems	6f 4f
Masculine (active) role erosion to which the client reacts with physical self protection	6f 6f2
Mixed and several different/conflicting medical diagnoses	6f
Client prefers to believe and speak of the most disabling and threatening diagnosis	6f
Client has had too many medical and treatment procedures, and has no faith left to invest	6f
Does not feel well enough examined medically or cared about. Wants more examinations	6f2 3f 5f
Physically tense at beginning of contact	7s
Physically self protective at start	7s 1s
High expectations from physical treatments, optimism fading at initiation of psychological treatment	2s
No compensation system problems	2s
A successful surgery during psychotherapy contact	2s
Spouse got a job, relieved financial strain	2s
Client contacted psychologist about self-control issues	2s
Client confronts significant other and wins, while in therapy	2s

Vocational clarification occurred	2s 1s
At discharge the client is physically different in presentation, cheerful, smiling, communicative, more mobile	2s
Client put physicians on pedestal initially. High expectations were unfulfilled	5f
Initial injury occurred more than 10 yrs ago, and was intermittently manageable	5f
Multiple failed surgeries	5f
Good family relationships	5s
Psychologist helped client over physical setback	5s
Activity increases low back pain	5s
Good relationships with other centre therapists	5s
Client is part of close-knit community	5s
Client is bright	5s
Client works up to the point of pain	5s
Client is an immigrant	5s 4f
Client feels dependent on WCB, does not believe he could be well again	5f
Client is doing the treatment procedures only to please the therapist.	5f
Outsider with a dead end job goes to a good job. Reinclusion into the world took place and the therapist is a part of that process	2s 1s
Therapist was reluctant to witness self-exploration because it was too frightening & violent, but did	2s
Client has actual experience of killing people and wants to confess to someone, despite previous therapist's rejection and rejection by other community members	2s
Client has been previously with psychology and/or spent a long time there receiving therapies of one kind or another	2f
Client has an ugly, scary, socially unacceptable appearance	2f
Low back, leg pain, poor sleep, multiple drugs	2f
Divorced	2f
Took part in therapy to please and belong but was not interested in changing	2f
Client alternates between agreeing to go along with therapist's plans, and distancing and fighting	2f
Client appears to be manipulating	2f
Substance addiction and blaming others for it rather than trying to change	2f

Structured pain control program, group, therapeutic excercise, behaviour modification, relaxation training group plus individual therapy 2f 4s

Low education, training, and job qualifications 2f 4s 4f

Grandiose and unrealistic plans and no followup in action 2f

Poor self-confidence 2f

Many years of involvement with various compensation boards 2f

Will take pill or have surgery but not biofeedback or other self-help therapeutic efforts 2f

Low back pain is a long term problem; whole life was derailed 4s

Change was like a religious conversion. A wholesale reframing of life experience took place 4s

Was in Centre on a number of previous occasions 4s

Was told there was no more physical treatment to be had. This scared him to attend more thoughtfully to therapies offered. 4s

Despite having tried all, client still wanted more treatment 4s

Worked on therapeutic tasks despite the pain, worked through the pain 4s

Family was involved in the treatment program at home (diet) 4s

Continued weight loss after end of therapeutic contact 4s

Simultaneous family tragedy and some related personal difficulties 4s

Extensive social involvement 4s

From a dependent'let someone else fix it' to independent self help attitude 4s

Limited money from compensation 4s

Too glum to be brought around 4f

Extensive family obligations 4f

Client felt society owed him. Described as a martyr 4f

Would not follow excercise instruction in weight room 4f

Saw resolution in enough money to start own business 4f

Smoked more 4f

Sleep loss 4f

Saw psychology as a place sheltered from pressure to excercise and job hunt 4f

Client liked the relationship in therapy and the ventilation	4f 1s
Client had a lawyer represent him with the Board	4f
Client had many previous experiences of up and down	4s2
Worked for some months after accident, until could not	4s2
Client had trouble justifying relationship between accident and disability because of time delay	4s2
Doctors told him he won't work again, psychologist told him that everyone can do something	4s2
Lost most possessions, experiencing financial strain	4s2
Had been in his own business	4s2
Positive mood developed in relation to vocational opportunity	4s2
Client became depressed again because there was no work	4s2
The spouse had been the family invalid until the accident	4s2
Client recovered positive mood following improvement after chiropractic care	4s2
Client wanted education financed by Board	1s
Client was in charge of the therapeutic relationship and wanted to learn specific skills or techniques	1s
Client felt he had to prove his honour. Therapist said taught him to concentrate on actual improvement	1s
Client learned to trust and accept the therapist, and through him the compensation system	1s
Client was described as nice looking	1s 1f
Client wanted out of the low back pain and was willing to lend self to the psychological treatment	1s
Client was fed up with assurance	1s
When he didn't improve under standard medical treatment and was blamed for the problem, client resented it.	1s
Worked through the pain	1s
Client lost confidence in the medical approach interpersonally and as a science	1s
Wanted to get on with life	1s
Family difficulties	1f
Street person, social outcast	1f
Trying to prove self to person in authority, and losing	1f
Needed constant attention from therapist and others	1f

Inconsistent physical complaint and no physical signs to document 1f

Presented self as victim in need of aid 1f

No willingness to accept self-responsibility 1f

Did not want therapist to attempt to cause change, just to attend 1f

Seductive, manipulative, wanted to touch therapist, exhibitionistic 1f

Money from compensation was threatened by improvement 1f

Therapist switched to authoritative approach after failure at less directive approach 1f

Therapist attributes failure of treatment to reinforcing power of money, and social life in Rehabilitation Centre 1f

VITA

Robert John Faltin

PLACE OF BIRTH: Prague, Czechoslovakia

DATE OF BIRTH: May 21, 1947

MARITAL STATUS: Married, two children

INTERESTS: Painting, printmaking, photography, writing, bicycling, running, camping, mountain climbing, blacksmithing.

POST-SECONDARY EDUCATION AND DEGREES:

Los Angeles City College
Los Angeles, California
1965-1967 Asc. A.

McGill University
Montreal, Quebec
1967-1969 B.Sc.

Lakehead University
Thunderbay, Ontario
1969-1973 Honours B.A. M.A. Clinical Psychology

University of Alberta
Edmonton, Alberta
1978-1980 Ph.D. Course work and practicums completed
1980-1987 Ph.D. Thesis completed

RELATED WORK EXPERIENCE:

February 1985-present, Full time.
Senior Psychologist, Workers' Compensation Board of Alberta.

-individual and group therapy, supervision of M.A. student, supervision of psychologists and psychometrists, supervision of the work of contract psychologists, acting department chief (Dec. '86-Jan.'87), input in personnel and equipment selection, production of annual reports and budget analyses, educational presentations to groups and individuals inside and outside the department, purchasing of equipment, as well as full scope of other typical duties of a psychologist, including research, peer review and workshop attendance.

August 1980-February 1985, Full time.
Psychologist, Workers' Compensation Board of Alberta.
-individual and group therapy, testing, research, treatment program design, consultation to other departments, involvement in hiring decisions, union representative for department members.

April-June 1976,
-spring session Lecturer, Lakehead University; teaching third year extension course in Abnormal Psychology.

September 1974-July 1978, full-time.
-Psychometrist II, St. Thomas Psychiatric Hospital, St. Thomas, Ontario; individual and group psychotherapy; assessment and diagnosis on admissions and treatment of long term patients; design, implementation and administration of behaviour modification programs for aggressive retarded patients (specialized provincial ward), for male disturbed patients, and for high risk female psychotic patients (specialized provincial ward); member of interdisciplinary travelling community service teams; member of Mental Health week planning committee and committee assessing transfers between the psychiatric hospital and Ministry of Social Services facilities for the retarded; involved in staff education programs necessitated by re-designation of treatment areas.

September 1971-April 1973
-internships associated with the M.A. program at Lakehead University; Lakehead Public School Board; Lakehead Psychiatric Hospital; Provincial Correctional Farm, teaching assistanceships;
full-time, three month internship at the Lakehead Psychiatric Hospital.

CERTIFICATION:

Certified Psychologist, Province of Alberta, 1978

MEMBERSHIPS:

Psychologists' Association of Alberta. 1978
Canadian Register of Health Service Providers in Psychology. 1986
Health Sciences Association of Alberta. 1982

CONTINUING EDUCATION:

1987, Effective Writing Course, N.A.I.T.
1986, Organizational Management Course, W.C.B.
1985, Phenomeneological Methodology Conference, University of Alberta.
1983, Hypnosis Workshop, Calgary.
1976, Ontario Department of Health; Management trainging program, workshops in Family therapy, Brief therapy, and Biofeedback, at the St. Thomas Psychiatric Hospital.

PRESENTATIONS:

1987 "Biofeedback treatment of chronic low back pain in a group format" to claims personnel at the WCB Rehabilitation Centre Edmonton, Alberta.

1987 "Biofeedback treatment of chronic low back pain in a group format" to specialized pension adjudicators, central office, Edmonton, Albera.

1986. "Principles of Vocational Testing " to province-wide vocational rehabilitation counsellors meeting at the Workers' Compensation Board of Alberta.

1986. "Application of Vocational Testing Procedures to W.C.B. Rehabilitation Centre Patients" to Workers' Compensation Board of Alberta vocational rehabilitation counsellors.

1981, Presented research findings on biofeedback treatment of chronic low back pain clients at Biofeedback Society of America conference in Chicago

1981 to 1985: Variety of workshops for various disciplines of the WCB of Alberta, on the topics of psychological assessment and treatment.

PROJECTS:

1987 Co-Editor, Canadian Workers' Compensation Quarterly

1986 Editor, Society for Behavioural Medicine and Biofeedback Newsletter

PUBLICATIONS:

(1) Faltin, R., Sungaila, P., Hershman, I., and Dickinson, M. (1981). The Chronic Lower Back Pain Patient in Motion: an E.M.G. based Treatment Program which Teaches Control of Motion-Induced Spasms. Biofeedback Association of Alberta Newsletter. 4 (2) 10-12.

(2) Faltin, R. and Dickinson, M. (1984). Hard-nosed Research and Soft-nosed Life: Correspondence. Canadian Psychology. 25 (I) 72-73.

(3) Faltin, R. (1984). The White Hotel: Book Review. Society for Behavioural Medicine and Biofeedback Newsletter 7 (1) 8.

(4) Flugelstein, R. J. (Faltin, R.J.) (1984). The Trouble with Therapy. Alberta Psychology. 13 (1) 6.

(5) Flugelstein, R .J. (1984). The Sea Snake. Alberta Psychology. 13 (2) 14.

(6) Faltin, B. (1984). Swimming Headfirst: the Views of a Team Canada Psychologist. An Interview with Jim Evans. Alberta Psychology. 13 (3) 15-17.

(7) Flugelstein, R. J. (1984). Misunderstanding. Alberta Psychology, 13 (3) 24.

(8) Faltin, B. (1984). A Psychologist at the Olympics: an Interview with Dr. Jim Evans. Alberta Psychology, 13 (4) 18-19.

(9) Faltin, R. (1985). The Chain of Chance: Book Review. Society for Behavioural Medicine and Biofeedback Newsletter, 8 (1) 16-17.

(10) Flugelstein, R. J. (1985). The Eye of Life. Alberta Psychology, 14 (3) 29.

(11) Faltin, R. "Threads", second prize in the short story category of the Edmonton Journal's 1985 Literary Awards Competition.

(12) Faltin, R. (1985). Rehabilitation: When is Enough Enough? Alberta Psychology, 14 (5) 19-20.

(13) Faltin, R. (1986). Sex from the Lips of the Wise and the Famous. Alberta Psychology, 15 (2) 29.

(14) Flugelstein, R.J. (1986). The Art of Good Communication. Alberta Psychology, 15 (2) 29.

(15) Faltin, R. (1986) "The Psychology and Biology of Terrifying Dreams: Book Review", Society for Behavioural Medicine and Biofeedback Newsletter, (June) 8-9.

(16) Miller, H. and Faltin, R. (1986). The Joy of Biofeedback. Alberta Psychology, 15 (4) 6.

(17) Miller, H. and Faltin, R. (1986) "Simple Biofeedback Technique Creates Independence for Injured Worker", The Communicator, 19 (3) 2.

(18) Flugelstein, R. J. (1987). A Hollow Plague: Book Review. Alberta Psychology, 16 (3) 29.

IN PRESS:

(19) Evans, J. and Faltin, R. Accepting Limits and Going Beyond. Canadian Journal of Rehabilitation.

(20) Geriatric Psychology, and interview with P. McGaffey. Alberta Psychology Sept. 1987.

(21) Falgaard, R. J. (Faltin, R. J.) Going Home. Espionage

ART:

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